MARATHON GROUP COUNSELING WITH IMPRISONED FEMALE DRUG ABUSERS

BY

RICHARD COLLIN PAGE

A DISSERTATION PRESENTED TO THE GRADUATE COUNCIL
OF THE UNIVERSITY OF FLORIDA
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE
DEGREE OF DOCTOR OF PHILOSOPHY

UNIVERSITY OF FLORIDA

1976

ACKNOWLEDGMENTS

The author wishes to acknowledge several persons who have contributed to the inception, development, and completion of this study:

Robert Myrick, chairperson of the doctoral committee, whose ideas, questions, and encouragement were indispensible;

Jerald Bozarth, committee member, whose advice and support expanded the scope of this project;

Paul Fitzgerald, committee member, who graciously consented to serve during the final quarter of this study when much was demanded;

E.L. Tolbert, former committee member, whose other responsibilities made his replacement on the committee necessary, but whose contributions were still substantial;

Bruce Thomason, formerly Professor of Rehabilitation Counseling and committee member, a teacher, friend, and mentor for many years.

TABLE OF CONTENTS

LIST OF TABLES

Abstract of Dissertation Presented to the Graduate Council
of the University of Florida in Partial Fulfillment of
the Requirements for the Degree of Doctor of Philosophy

MARATHON GROUP COUNSELING WITH IMPRISONED FEMALE DRUG ABUSERS

By

Richard Collin Page

August, 1976

Chairman: Robert D. Myrick
Major Department: Counselor Education

The purpose of this research was to assess the impact of marathon group counseling on changing selected attitudes of incarcerated female drug abusers. The population studied was female inmates of a Southeastern correctional institution who regularly abused illicit drugs before being imprisoned. Most of these females were imprisoned because they committed crimes (sales of drugs, armed robbery, grand larceny) to support their drug habits. The effects of treatment on inmates who had been addicted to heroin and on inmates who had abused drugs other than heroin (amphetamines, barbiturates, or psychedelics) were also assessed.

Fifty-six inmates were selected randomly from the population of female drug abusers at the correctional institution to participate in a control or a marathon counseling group. Two pairs of group leaders were assigned randomly to the two experimental groups.

The group leaders conducted the two marathon groups on the same day. These groups lasted for 16 hours and were unstructured marathons in that few exercises were used. A Marathon Group Strategy was developed to define the type of treatment the marathon leaders would use. One goal of the leaders was to help drug offenders develop mutually enhancing ways of

relating to peers and authority figures. A second goal was to help group members find solutions to personal problems which contributed to their drug abuse.

Three instruments were used to test the hypotheses of this study: the FIRO-B, a semantic differential, and a Marathon Group Questionnaire. The Marathon Group Questionnaire was developed specifically for use in this research. The attitudes assessed by the different instruments related to the feelings of the research participants toward interpersonal relationships, counseling, self, others, drugs, the past and future, and authority.

The research participants were administered two sets of posttests. The first posttest administration was the day following the marathons and the second was 4 weeks later. The results were analyzed by an analysis of variance procedure.

There were only significant differences ($p < .05$) between the control and experimental group members on three of the 29 scales of the instruments used in this research. The marathon group participants scored significantly lower ($p < .05$) than the control group participants on the wanted affection scale of the FIRO-B on the second posttest administration, and lower on the potency scale of The Future on a semantic differential on the first and second posttest administrations. The marathon group participants scored significantly higher ($p < .05$) on the first posttest administration of the Confidence in Personal Involvements Scale of the Marathon Group Questionnaire. There were no additional significant differences ($p < .05$) when heroin users in the experimental and control groups and non-heroin users in the experimental and control groups were compared.

The results of this research were inconclusive. The differences found between control and experimental group subjects were not numerous enough to demonstrate the treatment was successful in changing the attitudes of the group participants in a comprehensive manner. The results indicated a need for further research.

CHAPTER I

INTRODUCTION

Drug abuse is a major problem in American society. Large numbers of young people experiment with drugs each year and many become addicted. Some of these persons are apprehended by the police for violations related to their drug abuse. Of those that are placed in jail and brought to trial, many receive prison sentences.

Drug abusers placed in prison often learn other ways to commit crimes because of their association with other inmates. Unfortunately, incarcerated drug offenders receive little help in prison to eliminate their drug dependence. Outside the prison environment, these persons frequently resume drug use or have further problems obeying the law. Rehabilitation programs are needed to help offenders refrain from drug abuse once they leave prison.

This study was designed to assess marathon group counseling as a treatment for facilitating positive attitude and behavior changes in incarcerated drug offenders.

Need for Study

How successful have programs been which attempted to rehabilitate drug abusers? What impact does individual and group counseling have on helping the addict function without drugs in society? The answers to these questions are complex and vary. At least one expert wrote that counseling is an ineffective method of helping addicts refrain from drug

abuse (Brecher, 1972). Other experts have maintained counseling can help drug abusers develop lifestyles which are drug free (Einstein & Garitano, 1972). The degree of success of rehabilitation programs for drug users is a debatable issue.

Rehabilitation programs in prisons have been criticized more severely than other drug programs (Brecher, 1972; Yablonsky, 1965). One of the problems of institutional programs is that inmates are often resistant to change because they feel they are forced to participate. Moreover, they tend to support one another in maintaining criminal codes of conduct (Yablonsky, 1965). The staffs of these programs often have negative concepts of drug abusers which prevent them from supporting rehabilitation rather than punishment as a means of working with prisoners. Brecher (1972) concluded that programs, such as the California Rehabilitation Center, have very low success rates when the criterion is the number of inmates who refrain from using drugs for the remainder of their lives.

It is probably unfair to assess the treatment outcomes of drug rehabilitation programs solely on the basis of whether participants ever again use drugs. Actually, there have been few attempts to determine the kinds of attitude or behavior changes produced in imprisoned drug offenders by different forms of treatment. Many studies (e.g., Ross, McReynolds,& Berzins, 1974; Steinfeld, 1970) failed to utilize experimental research designs or had other methodological flaws. These is a need for research which can help practitioners assess their therapeutic methods.

Purpose of the Study

Although group therapy or counseling has been used with imprisoned drug offenders, very little research has been conducted on the effects of these groups (Hendricks, 1971; Yablonsky, 1965). Some research has

been reported on the use of marathon groups to help incarcerated addicts develop attitudes which will enable them to remain drug free outside of prison (Kilmann, 1974; Kilmann & Averbach, 1974; Kruschke & Stoller, 1967; Ross et al., 1974). None of these studies however, had experimental designs and some assessed the outcomes of therapy by questionable self-report or staff ratings (Kruschke & Stoller, 1967; Ross et al., 1974). Thus, the effects of marathon group treatment on the attitudes and behavior of incarcerated drug offenders are largely undetermined.

The purpose of this study was to determine the impact of group counseling on the attitudes of incarcerated drug users. More specifically, the effects of marathon group counseling on attitudes related to self, others, drugs, the past and future, authority, and counseling were assessed. An attempt was also made to determine how marathon group participation affects members' perceptions of relationships with others and their degree of confidence in becoming involved in personal relationships.

Research Questions

The following research questions were investigated.

1. What effect does participation in a marathon group have on a subject's attitudes toward authority or such representatives of authority as (a) police officers, (b) prison, (c) prison staff, (d) counseling, (e) counselors?
2. What effect does a marathon group have on a participant's degree of positive identification with (a) men, (b) women, and (c) others who use drugs?
3. Is there a relationship between marathon group participation and an inmate's level of confidence (a) in forming positive human relationships, (b) in maintaining positive human relationships,

(c) in accepting the past and past mistakes, (d) in facing the future realistically?

4. Does participation in a marathon group contribute to an inmate's increased level of positive self-regard?

5. What effect, if any, does participation in a marathon group have on an inmate's attitudes toward drugs?

6. What differences are there in the ways heroin and non-heroin users respond to marathon group treatment?

7. If attitude changes occur, do these changes produced among the participants of a marathon group remain stable?

Some important terms are defined as they were used in this study.

Definitions

1. Marathon group. A marathon group is a relatively unstructured counseling group that meets for 16 continuous hours and is led by two leaders. The leaders focus on helping members develop positive, mutually enhancing ways of relating to one another.

2. Incarcerated drug abuser. Incarcerated drug abusers are inmates of a correctional institution who used illicit drugs before coming to prison and who were sentenced to prison either for possession of drugs or for attempting to obtain money for drugs by armed robbery, grand larceny, or sales of drugs.

3. Heroin abuser. Heroin abusers are incarcerated drug abusers who, on a form provided to them by a drug counselor, identified their most significant drug problem as heroin.

4. Non-heroin abuser. Non-heroin abusers are incarcerated drug abusers who, on a form provided to them by a drug counselor,

identified their most significant drug problem as something other than heroin, such as hallucinogenics, barbiturates, or amphetamines.

Summary of Chapter Contents

A review of the professional literature is provided in Chapter II. This literature review includes a description of the personality characteristics of heroin and non-heroin abusers and a review of drug treatment programs. Marathon group theory, research on the use of marathon groups with drug free populations, and a description of the ways marathon groups have been used with drug abusers, specifically drug abusers who were inmates of correctional institutions, are discussed.

The experimental procedures for the study are described in Chapter III, including descriptive information on the population, sampling procedures, experimental design, research hypotheses, instruments, the marathon group treatment, and an outline of the steps of the study. The results of the study are in Chapter IV. The last chapter, Chapter V, contains a brief summary of the study and the author's conclusions and recommendations.

CHAPTER II

REVIEW OF RELATED LITERATURE

The review of the literature related to this investigation is divided into these broad areas: (a) reasons for drug abuse, (b) personal and social characteristics of heroin abusers, (c) personal and social characteristics of other drug abusers, (d) treatment of drug abusers, (e) marathon group theory, (f) research on marathon groups, (g) marathon group counseling with drug abusers, (h) marathon group counseling with imprisoned drug abusers, and (i) summary of the literature.

Reasons for Drug Abuse

Various investigators provide different answers regarding the reasons people abuse different kinds of drugs. The explanations cited often appear to depend more on the biases of a particular investigator than on anything else.

Some experts believe certain types of people have problems which cause them to turn to drugs as an escape. Other investigators think the breakdown of values in modern society causes persons to turn to drugs to find some meaning in life. Perhaps both ideas have merit.

For example, some investigators associate the increased abuse of drugs in modern society with the problems of living in a highly mobile, materialistic culture (Canadian Government Commission of Inquiry, 1970; Dohner, 1972b). The members of the Canadian Government Commission of Inquiry felt young persons abuse drugs because of their lack of ambition

and because they lose faith in reason, turning instead toward more hedonistic lifestyles. The collapse of traditional religious values and urban ugliness were also viewed as contributing to Canada's drug problem.

Dohner (1972b) associated peer pressure, an attempt to gain psychological support, and the tenseness of young people as an explanation for the increasing abuse of drugs by young Americans. He felt the general dissatisfaction of young persons with modern life caused young Americans to abuse drugs.

At least one writer maintained that many people use drugs illegally because human beings have an innate drive to alter normal consciousness states (Weil, 1972). Weil (1972) considered the urge to use drugs to produce pleasant sensations as analogous to the sex or hunger drives of people. He hypothesized people use drugs because they become more intuitive, are better able to accept ambivalance, and experience infinity through drug use. According to Weil, the only way to prevent drug abuse is to help people learn natural ways to achieve consciousness states similar to drug induced consciousness states.

Even though some writers have suggested general theories for drug abuse, others considered it more accurate to discuss the motivations of abusers of certain groups of drugs such as heroin, barbiturates, psychedelics, and cannabis (Braucht, Brakarsh, Follingstad,& Berry, 1973; Canadian Commission, 1970; Crowley, 1972). These various types of drugs alter feeling states differently. Abusers may be attracted to a particular type of drug because they gain relief from personal problems or anxieties. Crowley (1972) maintained persons use drugs to gain relief from stress associated with unresolved problems or inadequate personal

relationships. The personal and social characteristics of the abusers of different types of drugs are described extensively in the literature.

Personal and Social Characteristics of Heroin Abusers

Heroin addicts have been described as being the most difficult group of drug abusers to rehabilitate (Brecher, 1972; Lindesmith, 1966). Brecher (1972) wrote that heroin changes the body chemistry of the abuser in such a way that most addicts can never remain drug free in society. He asserted the only available cure for heroin addiction is for the addict to substitute the lifelong use of methadone for heroin. Page and Myrick (1975), using a semtantic differential with 85 drug abusers, found incarcerated heroin addicts viewed drugs as being significantly ($p < .05$) more potent than did incarcerated abusers of other drugs. These results were interpreted as showing that drugs have more power over the lives of imprisoned heroin users than the lives of imprisoned non-heroin users. What makes persons with heroin problems such a difficult group to rehabilitate? What makes the appeal to drugs so intense to heroin addicts?

Causes of Heroin Addiction

An attempt can be made to answer those questions by examining the reasons heroin addicts feel compelled to use narcotic drugs. One popular theory relating to heroin addiction emphasizes certain predisposing personality characteristics toward addiction (Chein, 1966; Eldridge, 1963; Isbell, 1966; Laurie, 1971; Winich, 1963). Winich (1963) emphasized one of the principle tenants of this position when he stated, "The addict is responding to underlying personality problems of great complexity (p. 49)." According to some theorists, addicts have personality characteristics which attract them to heroin as an escape from reality. These theorists

think addicts were either born with certain types of character weakness or developed character deficiencies early in life.

Winich (1963), for instance, explained heroin addiction from the perspective of Freudian psychology. He maintained heroin addicts often have had poor heterosexual relationships, unresolved Oedipal conflicts, or passive oral dependent personalities before they became addicted. These unresolved personal conflicts caused these persons to seek an escape by using heroin. Winich further suggested addicts also learned to use heroin as a replacement for sex by substituting drug induced feeling states for their sex drives. Other writers maintain addicts have character disorders or neurotic problems which predetermined their use of heroin (Chein, 1966; Eldridge, 1963; Isbell, 1966). Laurie (1971) stated many addicts use heroin because they had schizophrenic personalities before they became addicted. These persons chose to use heroin as a means of medicating themselves.

Heroin addicts have been described negatively by many writers. Lichtenstein (1966) called heroin addicts liars and mental and moral degenerates. He advocated hard work as the only treatment for heroin addiction. Mills (1966) labeled heroin addicts as habitually dirty, childishly immature, narcissistic, and irresponsible. Lichtenstein and Mills offered no explanation for why addicts become addicts.

There were others who disagreed with these negative descriptions of the addict's personality (Brecher, 1972; Canadian Commission, 1970; Fort, 1966; Grinspoon & Hedblom, 1975; Lindesmith, 1966; Ray, 1972; Schur, 1963). Fort (1966) agreed addicts often have neurotic character traits but he felt addicts become this way as a result of their addiction to heroin. He described drug-free addicts at the U.S. Public Health

Service Hospital in Lexington, Kentucky, as being introverted, friendly, sensitive, and quiet. Others have gone even further in disagreeing with the character weakness theory of addiction.

One group of theorists denied that heroin addicts have any abnormal personality characteristics which differentiate them as a group from normal persons. The proponents of this theory stated heroin users begin using drugs for pleasure and continue using these drugs because of their fear of the pain associated with withdrawal from heroin (Lindesmith, 1966; Schur, 1963). Lindesmith (1966) supported this theory by pointing out many addicts deny ever experiencing euphoric feeling states from heroin use. He also stated the fear of the addict of the dreadful pain of withdrawing from heroin causes addicts to keep using the drug.

Brecher (1972) advocated a modified version of the Lindesmith theory of addiction. Brecher stated addicts stay addicted to heroin because they experience anxiety, depression, and craving for the drug--the heroin abstinence syndrome--when they don't use heroin. According to Brecher, this syndrome probably continues to operate years after the addict has not used drugs, causing heroin addiction to be incurable.

Grinspoon and Hedblom (1975), however, disagreed with the Lindesmith theory of heroin addiction. They asserted the unpleasantness of the heroin abstinence syndrome was greatly overestimated by Lindesmith and the other advocates of his theory of addiction. Grinspoon and Hedblom stated addicts probably display drug-seeking behaviors because they seek to re-experience the euphoric feelings associated with their first heroin trip, or because they want to gain a sense of identity by being a part of the addict subculture. Persons thus become addicted to heroin in part because they enjoy the excitement of the addict's lifestyle.

Other theories about the causes of heroin addiction have been advocated. Eddy (1963) stated addicts are spiritually sick persons who cannot find meaning in life. Still others suggested the laws in the United States, which make addiction a crime, victimize the addict by forcing him to illegally support his habit (Finestone, 1966; Lindesmith, 1963b). Finestone and Lindesmith maintain the laws in America operate to drive up the price of drugs which forces the otherwise passive addict to resort to self-centered, antisocial, and criminal behavior to support his drug habit.

Others have maintained heroin addiction is caused by children being reared either in an unsupportive slum family, or by the children of slums associating with drug-using peers (Feldman, 1970; Lewis & Glaser, 1974; Seldin, 1972). Feldman (1970) stated many slum dwellers become addicted because the tension relaxing properties of heroin provide relief from an otherwise violent and depressing lifestyle. Seldin (1972) stated heroin addiction is more common among slum children reared in unsupportive homes than among children reared in supportive homes. He wrote that children with absent fathers and emotionally ill mothers often become heroin addicts when they reach adulthood.

Some writers have also written there are multiple causes of heroin addiction, which means it is fruitless to look for a single theory to explain in a global way the reasons everyone addicted to heroin became addicted (Canadian Commission, 1970; Ray, 1972). These theorists do not feel all persons addicted to heroin necessarily became addicted for the same reason.

Research on Personality Characteristics of Heroin Users

Thus, numerous theories of why people become addicted to heroin have been proposed. Many of the theories presented so far were not formed

from the results of research; rather, they evolved from the professional opinions and descriptions of experts who had worked to rehabilitate heroin addicts.

Several studies have been conducted using test data as an attempt to determine the personality characteristics of drug abusers (Berzins & Ross, 1973; Chambers, 1971; Gendreau & Gendreau, 1973). Chambers (1971), for example, administered the 16 PF personality test to heroin addicts certified for treatment by the 1971 New York State Narcotic Control Commission. He found 20% of these addicts were above average in neurotic maladjustment, and that 29.3% were above average in their anxiety levels as measured by the 16 PF. Data was also obtained with the 16 PF which showed 32.7% were above average in irresponsible acting out behavior, and 30% were below average in effective behavior controls. Chambers interpreted this data as showing most of these addicts, being in the normal ranges of this test, had normal personalities.

Using prisoners as subjects, Gendreau and Gendreau (1973) compared the MMPI profiles of eight heroin addicts with nine non-heroin addict volunteers for treatment. They also compared the profiles of 13 addicts with 20 non-addicts who did not volunteer for treatment. No significant differences were found in the types of profiles of these groups.

Berzins and Ross (1973) compared 600 opiate users at the Lexington Clinical Research Center with 800 students at the University of Kentucky on the dimensions of internal-external control as measured by Rotter's Internal-External Locus of Control Scales. The addict group exceeded the student group in levels of internal control at the .025 level of significance. Since most researchers using this instrument consider it a treatment goal to help subjects become more internally controlled, the

subjects of this study had scores which most researchers would probably consider to be characteristic of adequately functioning persons. These three studies (Berzins & Ross, 1973; Chambers, 1971; Gendreau & Gendreau, 1973) supported the hypothesis that heroin addicts have normal personalities as measured by psychological tests.

There have also been studies related to the personality characteristics of black and white heroin addicts (Chambers, Moffett, & Jones, 1968; Miller, Sensenig, Stocker, & Campbell, 1973; Page & Myrick, 1975), and male and female addicts (Miller et al., 1973; Page & Myrick, 1975). Most of the research showed black and white and male and female heroin abusers have major differences in their social backgrounds and personal attitudes. Page and Myrick (1975), however, found black and white and male and female addicts have similar attitudes. They utilized a semantic differential to assess the attitudes of 85 heroin addicts at the Florida Correctional Institution on 11 psychological concepts, (Women, Men, School, My Vocational Future, Parents, Drugs I Took, Others Who Use Drugs, Past, Future, As I See Me, and As I Would Like To Be). They found black and white and male and female addicts to be homogeneous in their attitudes related to these concepts.

Two studies attempted to assess the value patterns of black addicts. Miller et al. (1973) used Rokeach's values ranking instrument along with traditional admissions instruments to determine if the values of 284 narcotic addicts admitted to the N.I.M.H. Clinical Research Center were sex or race related. Black addicts preferred the values of a comfortable life, equality, ambition, and intellect more than white addicts. White addicts rated interpersonal and intrapersonal relationships higher than black addicts. Also, Chambers et al. (1968) found 806 blacks admitted

to the Public Health Service Hospital at Lexington, Kentucky, were more likely than non-addict black groups to have been reared in a broken home, to have been a school dropout, and were less often legally employed. Many of these characteristics of black addicts appear to be representative of the lifestyles of blacks reared in slum environments.

The personal and social characteristics of male and female addicts have also been compared. Miller et al. (1973) found male addicts valued being ambitious, intellectual, logical, and self-controlled while female addicts valued being clean, forgiving, happy, and having inner harmony. Black female addicts were reared in broken homes and had intact marriages more often than black male addicts. The findings of Miller et al. suggest male and female addicts do not have a common set of values emerging from drug use but instead have different, sex-related values.

Personal and Social Characteristics of Female Heroin Addicts

Since this research will be conducted with female subjects, it is important to review in more detail the personal and social characteristics of female heroin addicts. Female addicts have been described as being seriously maladjusted persons who have average or higher than average intelligence (Cuskey, Premkumar,& Sigel, 1974). These females often fail to take proper care of their children (Cuskey et al., 1974). Yablonsky (1965) emphasized female addicts often engage in prostitution to support their drug habits which causes them to have considerable guilt and confused attitudes toward men. Additionally, Yablonsky asserted female heroin abusers are deeply sensitive persons but confused and in need of counseling.

Raynes, Climent, Patch,and Ervin (1974) compared personal and social information on 46 female narcotic addicts in the Correctional

Institution for Women in Framingham, Massachusetts, with the characteristics of 46 voluntary female admissions at the Drug Detoxification Unit at Boston City Hospital. They found few differences between the two groups in terms of age, race, or religion. The prisoners had a higher prevalence of psychiatric illnesses and used marijuana at an earlier age than the hospital group. On the whole the two groups were homogeneous in their social and personal characteristics.

Chambers, Hinesley, and Moldestad (1970) compared the characteristics of 168 black and white addicts admitted between June and December, 1965 to the U.S. Public Health Service Hospital in Lexington, Kentucky. They found black female addicts, when compared to white female addicts, were more likely to have engaged in illegal activities, including prostitution, and were less likely to have volunteered for treatment. Additionally, black females more often had been reared in broken homes and were more likely to have been labeled as having sociopathic personality disorders. Chambers et al. (1970) found important social differences exist between black and white female narcotics addicts.

It is thus very difficult to state with any degree of confidence the reasons people become addicted to heroin. Writers have presented many different versions of what causes a person to become addicted to the narcotic drugs. Most of the research conducted with heroin addicts failed to support the idea that these drug abusers have personality characteristics which predispose them toward addiction. The rehabilitation of heroin addicts is a difficult task.

Personal and Social Characteristics of Other Drug Abusers

It is difficult to discuss in a comprehensive way the personal and social characteristics of all drug abusers other than heroin abusers.

One reason is that the amphetamines, barbiturates, psychedelics, and cannabis have different pharmacological effects on the people using them. Thus, the same person may use different drugs to achieve different consciousness states. Also, these different types of drugs vary greatly in their addictive properties. For these reasons the personal and social characteristics of persons abusing amphetamines, barbiturates, psychedelics, and cannabis will be discussed separately.

Amphetamine Abusers

Amphetamine abusers have been described as being social outcasts in the drug culture and they are among the most difficult of all types of drug abusers to rehabilitate (Canadian Commission, 1970; Grinspoon & Hedblom, 1975; Kramer, Vitezslav, & Littlefield, 1967). Laurie (1971), on the other hand, stated that the use of amphetamines among many groups of people is a rather harmless habit. Thus, some writers describe speed as having few ill effects while others describe speed as having disasterous effects on its abusers. Then, what are the effects of speed abuse? What types of personal and social characteristics do speed abusers have?

The speed abuser (amphetamine abuser) often acts in rather bizarre ways when he uses high doses of speed. Grinspoon and Hedblom (1975) stated libidinal energy is increased among many users and fatigue is masked so that performance is improved on simple tasks. Most users display paranoid symptoms, which often include auditory hallucinations, when they use speed over a prolonged period of time (Brecher, 1972; Grinspoon & Hedblom, 1975; Kramer, 1970; Ray, 1972; Robbins, 1970). Many speed abusers also become violent while they are using speed; therefore, speed users frequently become involved in drug-related murders. Persons abusing speed commonly suffer from sleep deprivation because they often

stay awake for days when using speed (Brecher, 1972; Grinspoon & Hedblom, 1975; Kramer, 1970). Additionally, Grinspoon and Hedblom (1975) asserted the blood pressure of speed addicts rises causing many health problems, including possible brain damage.

The amphetamines have severe effects on the emotional and physical health of addicts who use them intravenously (Grinspoon & Hedblom, 1975). Not all persons using amphetamines, however, become addicted to these drugs or use them intravenously. Robbins (1970) classified speed abusers into three types: the confirmed speed freaks, the general dope freaks, and the occasional users. He maintained speed abuse, even when of a short duration, has lasting effects on the personality.

Most imprisoned speed abusers have serious drug problems which contributed to their being sentenced to prison. Confirmed speed abusers have been described as suspicious, self-centered, lacking ambition, hyperactive, and lacking an adequate self-concept (Canadian Commission, 1970; Carey & Mandel, 1968; Smith, 1970). These addicts are often considered outcasts even among other groups of drug abusers because of their compulsive and self-defeating behavior. They are frequently involved in petty crime. Many speed abusers live in communes where violence is common. Brecher (1972) postulated the severe depression many speed abusers experience when they are not using speed contributes to their high relapse rate. He also emphasized the difficulty of rehabilitating these addicts.

Barbiturate Abusers

Literature on the personal and social characteristics of barbiturate addicts is almost unavailable. One reason for the paucity of such articles may be that barbiturate addicts have many of the same personal

and social characteristics as alcoholics (Brecher, 1972). There are numerous articles on the personality characteristics of alcoholics. Another reason for a lack of information may be that many barbiturate addicts abuse more than one drug, using barbiturates and alcohol or barbiturates and speed simultaneously (Brecher, 1972). Only a relatively small number of persons use barbiturates intravenously because of the severe physiological and psychological effects of these drugs.

The symptoms of barbiturate abuse have been associated with apprehension, muscular weakness, tremors, repeated vomiting, twitches, delirium tremens, panic states, and brain damage. Death can result from effects associated with the withdrawal syndrome (Chambers, Brill, & Inciardi, 1972). The abuse of barbiturates at high doses also produces marked behavioral changes in its abusers such as confusion, irritability, fighting, and an unclean physical appearance (Essig, 1970). Barbiturate abuse has also been linked to the increased violence and high number of attempted or successful suicides among its abusers. Barbiturate use often contributes to an addict's initial depressed feeling state (Brecher, 1972; Canadian Commission, 1970; Chambers et al., 1972). The continual abuse of barbiturates thus has some pronounced physiological, behavioral, and psychological effects on its abusers.

Many persons experiment with barbiturates without becoming addicted to them. Wesson and Smith (1972) identified three different types of barbiturate abuse as chronic intoxication, episodic intoxication, and intravenous barbiturate use. Since incarcerated barbiturate addicts used these drugs frequently before imprisonment, the personal and social characteristics of barbiturate abusers seriously addicted to these drugs will be described.

Many barbiturate addicts have been described as being middle aged and coming from middle class backgrounds. These addicts often obtain their drugs from legal sources, such as doctors (Chambers et al., 1972; Laurie, 1971). Whitlock (1970) maintained barbiturate abusers usually have a very disturbed and almost non-existent sex life. Many addicts show lifelong patterns of personality disorders. Most addicts are isolated and lonely individuals which has contributed to their proneness to physical injury and abuse (Whitlock, 1970). Several writers indicated that many addicts attempt suicide, or are severely depressed persons (Brecher, 1972; Canadian Commission, 1970; Laurie, 1971; Whitlock, 1970). Many barbiturate addicts have severe medical problems such as weight loss and brain or liver damage (Brecher, 1972; Canadian Commission, 1970; Chambers et al., 1972). A higher percentage of women, primarily housewives, than men also appear to abuse the barbiturates (Cooperstock, 1971).

Psychedelic Drug Abusers

The effects of psychedelic drugs on the user are different in some important ways from the effects of the opiates, amphetamines, and barbiturates. The person using hallucinogenic drugs does not become physically addicted to these drugs, and there is no tendency to use these drugs in increasing quantities in a pattern similar to heroin (Fort, 1974). Most experienced users of drugs such as LSD tend to use these drugs in decreasing amounts (Ray, 1972). For these and other reasons, the persons using psychedelics often have personal and social characteristics different from the abusers of other drugs.

Experts have asserted it is very difficult to predict how the psychedelic drugs will affect an individual user (Brecher, 1972; Canadian Commission, 1970). The effects of these drugs on the user appear to vary

with the personality of the user, the setting in which the drug is used, the mood and emotional set of the user, the people present when the drug is used, and the dosage used (Brecher, 1972; Canadian Commission, 1970; Fort, 1974; Ray, 1972). Some people have experienced what they describe as highly pleasant feeling states while on LSD. Others have had psychotic adverse reactions which included paranoid delusions and hallucinations (Canadian Commission, 1970). For these reasons, it is difficult to generalize about how LSD affects the feelings of individuals using it.

Most LSD users probably do not take large quantities of this drug over long periods of time (Brecher, 1972; Canadian Commission, 1970). There are abusers, however, who do take large amounts of LSD regularly for periods of years (Blacker, 1970; Cheek, Newell, & Sarett, 1970; Jones, 1973; Smith, 1970). Cheek et al. (1970) indicated such persons gain an increased sense of intimacy by using LSD in groups. Smith (1970) maintained a psychedelic syndrome occurs among heavy users which includes a belief in magic and mental telepathy. An overt passivity and repression of anger also occurs among many users (Blacker, 1970; Laurie, 1971; Smith, 1970). Jones (1973) asserted heavy users become present oriented and often fail to have insight into their own motivations and behavior or the motivations and behaviors of others. They also become alienated from the traditional values in society, causing them to drop out of society. Some abusers also appear to have elevated MMPI scores on scales designed to measure depression, paranoia, and schizophrenia (Kendall & Pittel, 1971).

Cannabis Abusers

Unlike the literature on the psychedelics, at this time there are a number of books and articles relating to marijuana and to the personal

and social characteristics of marijuana users (Becher, 1944; Grinspoon, 1971; National Commission on Marihuana and Drug Abuse, 1972). The effects of marijuana are unlike the effects of most other drugs, although the use of high doses of marijuana may have certain perceptual effects which have similarities to the perceptual effects produced by some of the psychedelics. Persons do not become physically addicted to marijuana although a very small percentage of users may use marijuana more than once daily for periods of years (Grinspoon, 1971; National Commission on Marihuana and Drug Abuse, 1972). The effects of marijuana on all types of users is still a debatable topic.

The reasons people use marijuana are probably determined by a number of complex psychological and social factors (Grinspoon, 1971; National Commission on Marihuana and Drug Abuse, 1972). Recreation (Becher, 1944) or an escape from boredom (Schoenfeld, 1944; Wallace, 1944) have been suggested as reasons many people use marijuana. It is probably more meaningful to consider the motivations of different types of marijuana users than to make general statements about the reasons people smoke marijuana. Thus, several experts have grouped marijuana users by the amount of marijuana they smoke (Becher, 1944; Grinspoon, 1971; National Commission on Marihuana and Drug Abuse, 1972). Grinspoon (1971) discussed the personal and social characteristics of occasional users, social users, and pot heads. The characteristics of pot heads or heavy users will be discussed as this type of abuser is more frequently imprisoned.

The parents of heavy users of marijuana have been characterized as smoking marijuana or drinking alcohol with a greater frequency than most parents (Hockman & Brill, 1973). Marijuana use has been described as the most important activity in the heavy marijuana abuser's life (Grinspoon, 1971; National Commission on Marihuana and Drug Abuse, 1972;

Ray, 1972). Heavy users of marijuana tend to be irresponsible, non-conforming, often resistant to authority, and tend to lose interest in everything except smoking marijuana. Pot heads often display paranoid-like attitudes and rebel against the establishment (Grinspoon, 1971; National Commission on Marihuana and Drug Abuse, 1972). Grinspoon (1971) stated heavy users often become involved in illegal activities.

Much conflicting information has been published about marijuana abuse. Kolansky and Moore (1972) wrote that marijuana use may result in structural changes in cerebral cells in the brain. They saw 13 adults between the ages of 20 and 41, all of whom had smoked cannabis from 3-10 times per week for 13 months to six years. They noted a clinical syndrome in all of these subjects which included disturbed awareness of self, apathy, confusion, and poor reality testing. Therefore, these clinicians postulated marijuana use may result in permanent brain damage. These conclusions, however, were questionable because these doctors based their opinions on only a few subjects. The conclusions have not been supported by other research investigations (Becher, 1944; Canadian Commission, 1970; Grinspoon, 1971; National Commission on Marihuana and Drug Abuse, 1972).

Treatment of Drug Abusers

Although writers have disagreed on the causes of drug abuse, most agree the rehabilitation of persons with serious drug problems is a very difficult task. Different kinds of treatment programs have been attempted with varying degrees of success.

A number of investigators have attempted to identify the components of a successful treatment program with drug addicts (Brecher, 1972; Dohner, 1972a; Einstein & Garitano, 1972; Warner, 1973). Warner (1973) maintained drug rehabilitation programs should focus on changing the

behavior and attitudes of persons with drug problems rather than attempting to provide information to these persons. Einstein and Garitano (1972) stressed that persons involved with the rehabilitation of drug abusers should communicate to their clients the belief that addiction can be cured. Others have stressed professional or peer counselors can help addicts find alternatives to drug use (Brecher, 1972; Dohner, 1972a). Brecher (1972) suggested sensitivity training, encounter therapy, Yoga, and Transcendental Meditation may help addicts achieve alternate states of consciousness in a drug free manner.

Meditation has been suggested as an especially suitable alternative to drugs for drug addicts. Meditation tends to provide natural highs which lead to personal growth or personal insights. This can help addicts learn to relax and cope with tension (Campbell, 1974; Payne, 1973; Weil, 1972).

Other writers advocate individual counseling, claiming it can help addicts resolve personal problems through an expression of repressed feelings of anger and guilt (Jaffe, 1973; Myers, Myers, Tapp,& Tapp, 1972). Ketai (1973) asserted a special counseling method, peer observed psychotherapy, is effective with drug abusers. When this approach is used, a professional therapist first works individually with one client while other clients watch what he does. Once the therapist has finished, he encourages the observers to provide feedback to the client.

Other writers have stressed traditional group psychotherapy as a method to help addicts overcome drug problems. For example, Fort (1955) and Thorpe and Smith (1955) maintained that at least 10 sessions of regular group therapy helps addicts discover the reasons they used drugs

in the past and, subsequently, decreases the likelihood that these addicts will abuse drugs in the future.

The federal government has supported many different types of rehabilitation programs for drug abusers. The Task Force on Federal Heroin Addiction Programs (1974) evaluated the degree of success of several different types of programs using federal funds. This Task Force rated detoxification programs and daycare treatment programs as being rather ineffective as a means of helping addicts reduce the degree to which they were addicted to heroin. Residential treatment centers, such as Synanon, were rated as an effective means of helping addicts remain drug free once they returned to society from these programs. The Task Force on Federal Heroin Addiction Programs also advocated methadone maintenance programs be used as a temporary way to help addicts withdraw from heroin. The members opposed programs which encouraged addicts to use methadone indefinitely. This Task Force rated drug counseling and drug education programs for drug addicts in prison settings as ineffectual.

Lindesmith (1963a) and Brecher (1972) also criticized the number and quality of drug rehabilitation programs in the penal systems in the United States. Lindesmith (1963a) asserted drug abusers were punished in prisons rather than rehabilitated. Brecher (1972) stated drug rehabilitation programs in prisons failed to rehabilitate drug addicts.

There appears to be a dearth of research on treatment programs for inmates in correctional settings. Evaluation of the existing programs in correctional settings is difficult because of the meager number of articles in the professional literature on these programs. The available literature indicates that a few programs conducted by professional staff or by ex-addicts have been developed.

Professional therapists have used covert sensitization to help addicts learn to refrain from drug use. Covert sensitization is a behavior modification technique in which a therapist presents an adverse stimulus while a client is engaging in a behavior the therapist and client wish to extinguish. For example, therapists used covert sensitization with imprisoned heroin addicts by presenting undesirable stimuli, such as rats crawling over a dead body, while addicts imagined a scene associated with the abuse of heroin (Steinfeld, 1970; Steinfeld, Rautio, Rice,& Egan, 1974a).

Hendricks (1971) used family counseling in groups to help addicts at the California Rehabilitation Center develop positive family relationships. Family members came to the California Rehabilitation Center to participate in these groups. Hendricks claimed this treatment method helped to rehabilitate heroin addicts although he presented no data to support this claim.

Ex-addicts and ex-prisoners have also conducted rehabilitation programs in prisons to rehabilitate drug addicts. Synanon programs have been started in several prisons by former heroin abusers. These programs were based on the program of Synanon House in California where addicts help one another resolve drug problems in groups without the aid of professional therapists. The proponents of Synanon in prisons demand their incarcerated members act responsibly by cooperating with prison staff and by giving up prisoner codes of behavior. Members failing to change their behavior are confronted. Those members failing to conform are asked to leave the program.. Yablonsky (1965) reported that a Synanon program was so successful at the Nevada State Prison that prison officials granted the program leaders an honor camp for 20 participants.

Marathon Group Theory

It is apparent that more research is needed to determine the types of programs which will produce positive attitudinal and behavioral changes among incarcerated drug offenders. A few writers have maintained that marathon groups offer an effective way of helping imprisoned drug offenders to rehabilitate themselves (Kruschke & Stoller, 1967; Yablonsky, 1965). Before discussing the ways marathons can help incarcerated drug offenders, the actual theory and operation of marathons will be reviewed.

Mintz (1971) wrote that marathon groups can be divided into two major types, structured marathons and unstructured marathons. Schutz (1967b, 1971, 1973) wrote about structured group sessions which he called encounter groups. The leaders of encounter groups use various group exercises to facilitate interactions among group members. Persons joining these groups agree to follow certain principles of encounter, including open and honest expression, concentrating on feelings, staying in the here and now, assuming responsibility for one's own actions, attempting to express feelings by using the body, and others. The encounter group leader structures the encounter groups by using exercises and the principles of encounter to help people openly express their feelings to other members.

Schutz (1971) advocated other principles of groups which have had a major impact on the sensitivity group movement. He wrote that people have three interpersonal need areas which are inclusion, control, and affection. Encounter groups progress through the inclusion, control, and affection stages of group interaction. The FIRO-B was designed by Schutz (1967a) to assess these three interpersonal need areas. Additionally, he wrote members must work through emotional as well as physical blocks in groups in order to resolve personal problems. He

stressed the importance of group leaders using such therapeutic techniques as Kundalini Yoga, Rolfing, Bioenergetic exercises, Tai-Chi Chuan, and others in encounter groups to help members work through physical and emotional blocks.

Several proponents of marathons have stressed the therapeutic potential of prolonged groups which have an absence of structured exercises (Bach, 1966, 1967a, 1967b, 1967c; Coulson, 1970; Mintz, 1971; Rogers, 1970; Stoller, 1968a, 1968b). Leaders in these groups generally rely on the spontaneous interactions of members with one another to provide the material for group discussion. Rogers is recognized as one of the most influential of the advocates of prolonged groups, which are at least 24 hour long group sessions. Coulson (1970) also consistently stressed the therapeutic potential of Rogerian encounter groups.

Rogers (1970) and Coulson (1970) asserted their encounter groups evolve in growth-enhancing directions for group members when the group leader allows members to freely express themselves in a permissive group setting. They stressed the group leader often expresses constructive feedback directly to group members because the leader interacts with his members as a real person rather than as a transference figure. Rogers observed his encounter groups tend to begin with a milling around stage, and then move toward a stage where the description of past feelings occurs. He stressed the development of other stages which focus on the expression of negative feelings, confrontations among members, the expression of personal feelings of closeness among members, and others. He suggested these group stages develop by a natural evolutionary process, rather than because the leader forces their development.

Bach (1966) and Stoller (1968a, 1968b) conducted pioneer work on marathons when they led groups and formulated one of the first comprehensive theories to account for the operation of marathons. Both of these writers also conducted some of the first research on marathon group outcomes (Bach, 1967a, 1967b, 1967c; Kruschke & Stoller, 1967). The concepts Bach (1966) and Stoller (1968a, 1968b) formulated have influenced subsequent practitioners in many settings. Mintz (1971) also contributed to the literature by advocating a theory of the operation of marathons similar to the theory of Bach and Stoller.

Bach (1966), Mintz (1971), and Stoller (1968a, 1968b) advocated the use of unstructured marathons lasting from one to three days. During these groups, the leader openly provides feedback to group members so that other members will follow his example in providing feedback on the behavior of group members. The leader and other members also are expected to listen carefully when feedback is given to them. Members cannot escape the consequences of their behavior during the group because of the length of the group. Members receive feedback which encourages these persons to experiment with new, more appropriate ways of relating to people. The group members learn to accept responsibility for their own actions. These persons also learn to communicate honestly and openly with others, and to express anger as well as feelings of love and concern to others.

Stoller (1968b) indicated marathon groups differ from time-limited groups in a number of ways. He maintained members become highly involved with each other during marathons; that tension mounts in these groups as members risk exposing their feelings to others. Stoller asserted the high degree of involvement of the members enables the participants of marathons, more than the participants of many short groups, to learn how

to care for others. The time perspective of the marathon members is altered causing time to move by quickly during these meetings. Stoller maintained marathon group therapy differs from regular group therapy because of the extended time format, and the unstructured nature of marathons.

The stages of marathon groups have also been described by Stoller (1968a, 1968b). He viewed marathons as progressing through these stages by a natural evolution which occurs in all unstructured marathons. During the first stage, the members relate in a formalized style. They tell their stories to other members and receive feedback concerning how they affect one another. Stage two involves a more personal type of sharing. In this stage, members receive feedback on the openness and honesty with which others feel they relate. The focus shifts from what is presented to the manner of presentation. Behavior within the group becomes the major concern as group members are helped to relate in an open, honest, and caring manner. Stage three is one of urgency and elation. During this stage, positive feelings are expressed as members learn how to care for one another. The sense of urgency and elation come from the realization that mutual concern and care are possible.

Research on Marathon Groups

Many researchers have performed studies to determine if marathon groups are effective in producing attitudinal and behavioral changes among the members of different populations. Most of the research done on marathon treatment with these different groups tends to support the contention these groups have positive effects on the participants. Much of the research performed on marathons has been plagued by experimental design weaknesses and often by a lack of researcher objectivity

(Diamond & Shapiro, 1975; Kroeker, 1974; Marks, Conry, & Foster, 1973; Treppa & Fricke, 1972). These weaknesses make it difficult to assess the outcomes of research on marathon groups or to arrive at any conclusions concerning the utility of this form of treatment with different populations.

Diamond and Shapiro (1975) criticized much of this research because researchers failed to specify exactly what marathon group treatment entailed. Other writers pointed out that many marathon group researchers failed to use suitable instruments to assess outcomes, did not assign their subjects randomly to control and experimental groups, and/or used improper statistical techniques to analyze their data (Diamond & Shapiro, 1975; Marks et al., 1973). Marks et al., (1973) also aserted most marathon group researchers used only one instrument rather than multiple instruments to assess outcomes. Perhaps the most common criticism of the designs used in most of these studies involved the failure of the researchers to handle adequately pretest treatment interactions (Marks, et al., 1973; Treppa & Fricke, 1972). Several writers advocated that persons directing research projects on marathon groups should avoid the use of pretests in their research designs (Kroeker, 1974; Marks, et al., 1973; Treppa & Fricke, 1972).

Lieberman, Yalom, and Miles (1973a, 1973b) conducted what many persons consider to be the most comprehensive research investigation ever performed on encounter groups, the Stanford project. These researchers compared and contrasted the effectiveness of 10 group methods: National Training Laboratory groups, Gestalt groups, Transactional Analytic groups, Esalan Eclectic groups, National Training Laboratory groups--Western style, Synanon groups, psychodrama groups, marathons in George Bach style, psychoanalytically oriented groups, and encounter group (leaderless) tapes.

Experienced group leaders were used to conduct 17 groups which contained a combined total of 137 Stanford University students. The students were assigned randomly to treatment groups. A control group was also selected consisting of 69 students who could not attend the encounter groups because of schedule conflicts. Seventy-eight measures were used to assess outcomes; results were combined to assess five broad areas of change. Data was collected before the groups were held, two weeks after the groups ended, and again six to eight months later.

The Stanford project produced some rather startling results. One third of the participants in the treatment groups changed in positive ways, one third changed in negative ways, and one third showed no change. No particular type of group appeared to be more or less effective than any of the others in producing changes in members. However, leaders who moderately stimulated group members or who exerted a moderate amount of executive behavior in their groups were more effective than leaders without these behaviors. Perhaps the most startling section of the Stanford project involved Lieberman et al. (1973a) finding that 9% of the 179 members of these groups completing training sustained what they described as serious psychological damage six to eight months after these groups were held.

The Lieberman, Yalom, and Miles study produced some results which seriously challenge the effectiveness of encounter groups in helping people. The reports that people were seriously hurt in these groups contributed to skepticism about encounter groups. Recently Rowan (1975), Schutz (1975), and Smith (1975) criticized the research design and degree of objectivity of the researchers of the Stanford project. The criticisms of these writers were multifaceted and wide ranging. Miles (1975) and

Lieberman (1975) responded to these critiques but failed to answer the underlying arguments of Schutz, Rowan, and Smith.

Schutz (1975) gave several reasons why the comparisons made of the outcomes of the different types of encounter groups in the Stanford project were unjustified. The leaders in the various groups were not all equally qualified to lead groups, and the lengths of the meetings were different for different groups. Comparisons between the control groups and experimental groups were unjustified because the members were not assigned randomly to experimental and control groups. Both Schutz and Rowan stated that all of the comparisons of the Stanford study were compromised because the members of the experimental groups were warned before they entered treatment that they might incur psychological damage as a result of group participation. Therefore, the members may have entered these groups expecting to be hurt and this may have contributed to the negative group outcomes.

The Stanford project has also been criticized for other reasons. Rowan (1975) asserted the outcome measures used for this research were too complex, making the entire project unwieldy. Others stated it was inappropriate to use students as subjects when comparing the overall utility of different group methods because of the psychological instability of the student population. Schutz (1975), Smith (1975), and Rowan (1975) also claimed the Stanford project defined encounter group casualties in a sensational and prejudicial manner. It was contended that the fact Lieberman et al. (1973a) assigned subjects to a casualty status on the basis of interviews they conducted also contributed to the lack of objectivity of this project. The Stanford project offers an illustration of some of the major difficulties involved in conducting sound research on group therapy.

At least two major reviews of the research related to marathon groups, or sensitivity groups, have been undertaken (Diamond & Shapiro, 1975; Gibb, 1971). Diamond and Shapiro reviewed the results of over 10 research projects on marathon groups conducted by students and teachers of the University of Hawaii during a 42 month period. These groups were conducted with many different populations including teachers, prison inmates, correctional workers, police, students, nurses, and para-professional workers. Diamond and Shapiro pointed out that many of the faults of the Stanford project were eliminated by the research procedures with these marathons. For instance, all of these research projects contained group goals stated in operational terms. Everyone was pre- and posttested and experimental research designs were used. The participants in the great majority of these marathons showed positive behavior or attitude changes which included improvements in self-concept, the de-polarization of attitudes, and increased hypnotic suggestibility.

Gibb (1971) reviewed the research related to what he called human relations training. He defined human relations training groups as groups which focus on the here and now, on personal growth, on the available interpersonal data, on promoting interactions between members, and on encouraging members to try new behaviors in the group. Such groups are conducted with normal group members rather than with emotionally disturbed group members. Gibb stated that the research on these groups shows human relations training can help members develop positive feelings toward self, more positive perceptions of others, improved feeling management, and enhanced directionality of motivation. He stated the available evidence shows the dangers of sensitivity training have been vastly overrated.

Seven studies (Foulds, Guinan,& Warehime, 1974; Guinan & Foulds, 1970; Jones & Medvene, 1975; Kimball & Gelso, 1974; King, Payne, & McIntire, 1973; Weissman, Seldman, & Ritter, 1971; Young & Jacobson, 1970) studied the effects of marathon groups on university students. All of this research indicated marathon groups helped the students develop more positive outlooks toward themselves and others. However, the results obtained in these studies were weakened by some research design deficiencies. For instance, in these seven studies only two sets of researchers assigned subjects randomly to control and experimental groups (Jones & Medvene, 1975; Kimball & Gelso, 1974). Many of these researchers also failed to define adequately the types of marathons used in their studies, making replication of the studies impossible. It is therefore difficult to know how to evaluate the results of this research.

In spite of the limitations, these studies provide some evidence that marathon group treatment can bring about positive attitude changes among student populations. Research has shown that students participating in marathon groups changed more than members of control groups in the following ways: increased levels of self-actualization (Guinan & Foulds, 1970; Kimball & Gelso, 1974; Young & Jacobson, 1970), increased self-acceptance (Guinan & Foulds, 1970; King et al., 1973), gains in self-actualization by participants with average or above-average ego strength (Jones & Medvene, 1975), and increased self-understanding, self-confidence, and increased understanding of others (Guinan & Foulds, 1970). Additionally, student marathon group participants changed more than the members of control groups by achieving lower levels of dogmatism and a more open belief system (Foulds et al., 1974), and by increasing in tendencies to prefer complexity, novelty, and ambiguity (Weissman et al., 1971).

The effects of marathon groups on the attitudes and behavior patterns of other populations have also been examined, although not as thoroughly as with college students. Harrison (1966) found marathon group treatment produced an increased proportion of concepts dealing with feelings and emotions in the speech patterns of 115 businessmen participating in NTL groups. This research, however, failed to utilize a control group.

Posthuma and Posthuma (1973) compared the effects of a marathon group, 10 three-hour sessions of a placebo group, and a control group. Encounter group treatment produced more positive changes on the Edwards Personal Preference Schedule and the Behavioral Change Index among church members than did 10 three-hour sessions of a placebo group or a control group composed of students from a community college. This research was also characterized by design weaknesses, including the failure to assign subjects randomly to the control group, the placebo group, and the marathon group.

Chambers and Ficek (1970) studied the effects of marathon groups on the attitudes of female juvenile delinquents in a residential training school. They reported marathon group treatment increased the numbers of positive entries in the diaries of the marathon participants. This research had several design weaknesses, including the failure of the researchers to assign subjects randomly to the control or marathon group.

The available research on marathon groups supports the contention that marathon group treatment can produce positive personality changes in a variety of populations. Most of this research, however, has been compromised by design weaknesses.

Marathon Group Counseling with Drug Abusers

Marathon group counseling has been used successfully to help individuals belonging to different populations develop interpersonally and intrapersonally. There have been very few reports in the literature, however, concerning the use of marathons with drug abusers. Most of what has been reported has related to the use of day-long Synanon groups led by the staff of drug houses (24-hour residential programs) for the residents of their programs. Synanon groups have special characteristics which make them different from the marathons led by Stoller, Bach, Schutz, or Rogers.

Many writers have described Synanon groups as being an unconventional and radical approach to group treatment (Kramer, 1963; Ruitenbeek, 1970; Volkman & Cressey, 1966; Yablonsky, 1965). These groups stress confrontation and their leaders use such methods as attack therapy, or exaggerated statements or ridicule to help members overcome their drug dependency. Leaders encourage members to confront other members to help these members recognize their irresponsible and manipulative behavior patterns (Ruitenbeek, 1970; Yablonsky, 1965). These groups are led by former addicts rather than by professional group leaders. The advocates of Synanon groups think drug addicts need to be resocialized. Yablonsky (1965), for instance, stated drug addicts need to learn to conform to a healthy group norm in order to stop using drugs. He also stressed that the members of Synanon groups need to gain feelings of belonging and respect from other group members in order to gain the strength to overcome their drug dependence.

Densen-Gerber (1973), the director of Odyssey House, described one or two day long marathons she led for the women residents of Odyssey House (a 24-hour residential drug treatment program). The purpose of these

groups was to help the participants develop positive female identities. Densen-Gerber was the primary therapist of these groups, although different members of her staff served as co-therapists. She stressed that group leaders were to interact with group members as real persons rather than as transference figures. Densen-Gerber stipulated that the members of her groups were to be completely honest with each other although she also stressed the importance of offering hope and acceptance to honest members. Many themes emerged during these groups which often included the discussion of the members' feelings toward their children, men, sex, parents, religion, and race. Densen-Gerber asserted the members of these groups were often able to work through feelings of guilt by talking with other group members. She supported her claim that marathon groups have positive effects on their participants from her own experiences as a group leader and not from the results of research.

Marathon Group Counseling with Imprisoned Drug Abusers

Only a few articles are available in professional journals relating to the use of marathon groups with incarcerated drug offenders. Unlike the leaders of marathons in drug house settings (24-hour residential programs), the therapists of marathons with imprisoned drug addicts have generally been the professional staff of universities or the staff of prisons. Much of the research on this type of treatment in prison settings has been undermined by improper instrumentation or the lack of experimental or quasi-experimental research designs. This overall unavailability of sound research in this area points out the need for further studies to help determine whether marathons produce positive counseling outcomes with imprisoned drug offenders.

Marathon groups have been utilized as a treatment modality at the California Rehabilitation Center, the prison to which drug offenders are sentenced in California (Kilmann, 1974; Kilmann & Averbach, 1974; Kruschke & Stoller, 1967). In one research project, Kilmann and Averbach (1974) assigned 84 female narcotic addicts at this institution to two non-directive and two directive marathon groups. A control group was also used, although the authors said nothing about assigning subjects randomly to experimental and control groups. The subjects receiving non-directive therapy decreased in levels of A-Trait anxiety while those persons receiving directive therapy increased in levels of A-Trait anxiety (Kilmann & Averbach, 1974). The marathon group participants, to a greater degree than the control group subjects ($p < .05$), shifted toward being more externally controlled rather than internally controlled on Rotter's Locus of Control Scale. Kilmann (1974) interpreted the shift toward greater external control for the experimental subjects as involving a positive change for this population.

Kruschke and Stoller (1967) led a 20-hour marathon over a two day period with 10 volunteer drug addicts incarcerated at the California Rehabilitation Center. They identified group stages in which the members played psychologist, used the hot seat approach, told personal things about themselves, shifted from a discussion of past mistakes to emphasizing future successes, and expressed feelings of personal closeness for each other. Kruschke and Stoller maintained the group helped its members gain an increased understanding of the needs of staff, show a more positive outlook in their dormitories, and spend less time in prison than the average inmate of the California Rehabilitation Center. Kruschke and Stoller made no systematic attempt to assess the outcomes of their group

but instead were more concerned in providing their impressions of how marathons operate with incarcerated drug abusers.

Ross, et al. (1974) compared the effectiveness of marathon groups and conventional group therapy for female narcotic addicts committed to an NIMH facility under the Narcotic Rehabilitation Act of 1966. The subjects in the marathon groups decreased in their tendency to view the criminal subculture positively while the subjects in the traditional groups increased in this same tendency. Both marathon and traditional group treatment reduced the number of neurotic complaints of participants. But this research study had definite weaknesses; six subjects were assigned in a non-random manner to each of the treatment groups.

Summary of the Literature

The reasons persons chose to abuse drugs are complicated and are probably determined by a combination of factors. The abusers of different drugs, (i.e., opiates, amphetamines, barbiturates, psychedelics, and cannabis) often have different personal motives for abusing drugs. It is therefore more accurate to discuss the personal and social characteristics of specific groups of drug abusers than to discuss the characteristics of drug abusers as a whole.

Heroin abusers have been viewed as being among the most difficult groups of drug addicts to rehabilitate. The abusers of the amphetamines and the barbiturates also have major drug problems and are prone to use drugs for very long periods of time. LSD and marijuana users do not become addicted to these drugs and these users do not necessarily use these drugs in increasing amounts. Therefore, the abusers of LSD and marijuana often have quite different personal and social characteristics than the abusers of opiates, amphetamines, and barbiturates.

There have been many types of programs designed to rehabilitate drug abusers, including methadone maintenance programs, drug houses, and group counseling. There has not, however, been much written in the professional literature about programs or methods designed to rehabilitate incarcerated drug abusers. Marathon groups have been used successfully to help bring about positive attitude changes among student populations, businessmen, and young females in adjustment centers. Marathon groups have also been used as a treatment method in drug houses.

Since marathons have been used with reported success with other populations, or with drug addicts in drug houses, this form of treatment might also be used successfully to help incarcerated drug abusers. The types of personal changes marathon group treatment can bring about among incarcerated drug offenders has not been determined and this investigation is designed to further explore this question.

CHAPTER III

RESEARCH METHODOLOGY

An experimental research design was used to assess the effects of 16-hour marathon groups in changing the attitudes of incarcerated drug offenders. The subjects for this study were female drug addicts. A marathon group strategy was developed by the drug counselor to function as a treatment. The remainder of this chapter is devoted to a more detailed explanation of the research methodology used in this study.

Population

The population was composed of female inmates of the Florida Correctional Institution, Lowell, Florida, between March-April 1976, who were serving sentences for drug or drug related problems and who, prior to their imprisonment, regularly abused illicit drugs. These women came from all areas of Florida. At least 80% were between the ages of 15 and 35. Of this population, about 60% were black and 40% were white. Approximately 50% of these females were heroin addicts and approximately 50% abused other drugs (amphetamines, barbiturates, psychedelics, or cannabis). Alcoholics were excluded from participation in this study. Most of this population had been convicted of possession of illicit drugs, sales of drugs, grand larceny, armed robbery, or shoplifting. All of these persons indicated they had had serious drug problems, prior to their imprisonment, which contributed in some way to their being incarcerated.

The population of the institution at the time of this study was approximately 450 female inmates. About 150 of these inmates were serving sentences for drug or drug related problems and had regularly abused illegal drugs prior to their imprisonment. Most of the inmates comprising the population used for this study had sentences ranging from 6 months to 10 years. All of these inmates were assigned to work areas, educational or vocational programs in the institution, and all lived in dormitory settings. Some of them had received some form of counseling prior to their imprisonment, usually with drug counselors in jails, drug houses, or methadone programs, or perhaps with other professional counselors, psychologists, or psychiatrists. Some were also participating in individual or group counseling at the time of this study. The prior counseling experience of these inmates was a serious limitation to this study but if these females were to serve as subjects for this research, it was a limitation which could not be overcome.

Sample

At the time of this study approximately 106 inmates of the 150 inmates had requested of the drug counselor that they be included in group counseling. The drug abuse counselor interviewed 82 inmates randomly selected from the list of 106 inmates who had requested to participate in groups and identified 56 participants for this study. Twenty-six inmates declined to participate in a marathon group even though they had previously requested to be placed in drug groups. Some who refused to participate expected visitors on the weekend when the marathon would be conducted and were unwilling to give up seeing these visitors. All of the inmates who were interviewed were asked to give up visitation privileges during the time the groups met. Only volunteers were used. The experimenter

conducted all precounseling interviews, asking the subjects if they wished to participate in the study. Anyone who wished to participate was allowed to participate.

Assignment of Subjects

Using a table of random numbers, the subjects were assigned randomly to one of two experimental groups or to a control group. Fourteen subjects were assigned to each of the two experimental groups and 28 subjects were assigned to a control group.

Research Design

The Posttest Only Control Group Design (Campbell & Stanley, 1966) was used to test the hypotheses of this study. Instead of using only one set of posttests, however, all criterion instruments were delivered twice after the marathon groups were completed. The first set of posttests was delivered the day after the marathons were conducted. This set of tests ascertained the attitudinal changes of the marathon participants directly following the marathons. The second set of posttests was delivered to all the experimental and control group participants 1 month (4 weeks) following the first set of posttests. The second set of comparisons was designed to test the stability of any changes that may have resulted from the marathon group experience. A time period of 1 month was used between the two sets of posttests because inmates continually arrive at and leave the institution. The design used in this study may be diagrammed:

R	X	O_1	O_2
R		O_1	O_2

R random selection
X experimental treatment
O_1 first posttest
O_2 second posttest

The Posttest Only Control Group Design has both strengths and weaknesses. Campbell and Stanley (1966) stated that this design controls for these factors which often jeopardize the internal validity of research: history, maturation, testing, instrumentation, regression, selection, mortality, and the interaction of selection and maturation. The Posttest Only Control Group Design also controls for a factor often limiting the external validity of research, the interaction of testing and X. This design, however, does not always control for these factors related to the external validity of research: the interaction of selection and the experimental treatment, and reactive arrangements.

The Posttest Only Control Group Design controls for weaknesses characterizing much of the past research on marathon group outcomes. Much of the previous research on marathon groups inadequately controlled for the confounding influences of testing and the treatment (Kroeker, 1974; Marks, Conry, & Foster, 1973; Treppa & Fricke, 1972). When subjects of marathons take pretests, the short time period between pretests and posttests means many subjects may remember how they responded on the pretests when they take the posttests, or the pretest may sensitize participants to the types of changes the researcher wants to bring about by his treatment. The Posttest Only Control Group Design eliminates pretests in order to control for these confounding influences.

Hypotheses

This research assessed 19 hypotheses related to the effects of marathon group treatment on the interpersonal and intrapersonal attitudes of incarcerated female drug abusers. The study assessed attitudes relating to self, others, drugs, the past and the future, authority, and counseling. The attitudes of heroin and non-heroin users were assessed. The following null hypotheses were tested:

Ho:1 There will be no significant differences between experimental and control group subjects on the variable of expressed behavior in the area of inclusion, as measured by the FIRO-B.

Sub Ho:1a There will be no significant differences between heroin users in the experimental and control groups on the variable of expressed behavior in the area of inclusion, as measured by the FIRO-B.

Sub Ho:1b There will be no significant differences between non-heroin users in the experimental and control groups on the variable of expressed behavior in the area of inclusion, as measured by the FIRO-B.

Ho:2 There will be no significant differences between experimental and control group subjects on the variable of wanted behavior in the area of inclusion, as measured by the FIRO-B.

Sub Ho:2a There will be no significant differences between heroin users in the experimental and control groups on the variable of wanted behavior in the area of inclusion, as measured by the FIRO-B.

Sub Ho:2b There will be no significant differences between non-heroin users in the experimental and control groups on the variable of wanted behavior in the area of inclusion, as measured by the FIRO-B.

Ho:3 There will be no significant differences between experimental and control group subjects on the variable of expressed behavior in the area of control, as measured by the FIRO-B.

Sub Ho:3a There will be no significant differences between heroin users in the experimental and control groups on the variable of expressed behavior in the area of control, as measured by the FIRO-B.

Sub Ho:3b There will be no significant differences between non-heroin users in the experimental and control groups on the variable of expressed behavior in the area of control, as measured by the FIRO-B.

Ho:4 There will be no significant differences between experimental and control group subjects on the variable of wanted behavior in the area of control, as measured by the FIRO-B.

Sub Ho:4a There will be no significant differences between heroin users in the experimental and control groups on the variable of wanted behavior in the area of control, as measured by the FIRO-B.

Sub Ho:4b There will be no significant differences between non-heroin users in the experimental and control groups on the variable of wanted behavior in the area of control, as measured by the FIRO-B.

Ho:5 There will be no significant differences between experimental and control group subjects on the variable of expressed behavior in the area of affection, as measured by the FIRO-B.

Sub Ho:5a There will be no significant differences between heroin users in the experimental and control groups on the variable of expressed behavior in the area of affection, as measured by the FIRO-B.

Sub Ho:5b There will be no significant differences between non-heroin users in the experimental and control groups on the variable of expressed behavior in the area of affection, as measured on the FIRO-B.

Ho:6 There will be no significant differences between experimental and control group subjects on the variable of wanted behavior in the area of affection, as measured by the FIRO-B.

Sub Ho:6a There will be no significant differences between heroin users in the experimental and control groups on the variable of wanted behavior in the area of affection, as measured by the FIRO-B.

Sub Ho:6b There will be no significant differences between non-heroin users in the experimental and control groups on the variable of wanted behavior in the area of affection, as measured by the FIRO-B.

Ho:7 There will be no significant differences between experimental and control group subjects on the variable Counseling, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:7a There will be no significant differences between heroin users in the experimental and control groups on the variable Counseling, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:7b There will be no significant differences between non-heroin users in the experimental and control groups on the variable Counseling, as measured by the evaluative and potency scales of a semantic differential.

Ho:8 There will be no significant differences between experimental and control group subjects on the variable Authority, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:8a There will be no significant differences between heroin users in the experimental and control groups on the variable Authority, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:8b There will be no significant differences between non-heroin users in the experimental and control groups on the variable Authority, as measured by the evaluative and potency scales of a semantic differential.

Ho:9 There will be no significant differences between experimental and control group subjects on the variable Drugs I Took, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:9a There will be no significant differences between heroin users in the experimental and control groups on the variable Drugs I Took, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:9b There will be no significant differences between non-heroin users in the experimental and control groups on the variable Drugs I Took, as measured by the evaluative and potency scales of a semantic differential.

Ho:10 There will be no significant differences between experimental and control group subjects on the variable Others Who Use Drugs, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:10a There will be no significant differences between heroin users in the experimental and control groups on the variable Others Who Use Drugs, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:10b There will be no significant differences between non-heroin users in the experimental and control groups on the variable Others Who Use Drugs, as measured by the evaluative and potency scales of a semantic differential.

Ho:11 There will be no significant differences between experimental and control group subjects on the variable Parents, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:11a There will be no significant differences between heroin users in the experimental and control groups on the variable Parents, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:11b There will be no significant differences between non-heroin users in the experimental and control groups on the variable Parents, as measured by the evaluative and potency scales of a semantic differential.

Ho:12 There will be no significant differences between experimental and control group subjects on the variable Women, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:12a There will be no significant differences between heroin users in the experimental and control groups on the variable Women, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:12b There will be no significant differences between non-heroin users in the experimental and control groups on the variable Women, as measured by the evaluative and potency scales of a semantic differential.

Ho:13 There will be no significant differences between experimental and control group subjects on the variable Men, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:13a There will be no significant differences between heroin users in the experimental and control groups on the variable Men, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:13b There will be no significant differences between non-heroin users in the experimental and control groups on the variable Men, as measured by the evaluative and potency scales of a semantic differential.

Ho:14 There will be no significant differences between experimental and control group subjects on the variable The Future, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:14a There will be no significant differences between heroin users in the experimental and control groups on the variable The Future, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:14b There will be no significant differences between non-heroin users in the experimental and control groups on the variable The Future, as measured by the evaluative and potency scales of a semantic differential.

Ho:15 There will be no significant differences between experimental and control group subjects on the variable The Past, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:15a There will be no significant differences between heroin users in the experimental and control groups on the variable The Past, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:15b There will be no significant differences between non-heroin users in the experimental and control groups on the variable The Past, as measured by the evaluative and potency scales of a semantic differential.

Ho:16 There will be no significant differences between experimental and control group subjects on the variable My Real Self, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:16a There will be no significant differences between heroin users in the experimental and control groups on the variable My Real Self, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:16b There will be no significant differences between non-heroin users in the experimental and control groups on the variable My Real Self, as measured by the evaluative and potency scales of a semantic differential.

Ho:17 There will be no significant differences between experimental and control group subjects on the variable Confidence in Personal Involvements, as measured by the Marathon Group Questionnaire.

Sub Ho:17a There will be no significant differences between heroin users in the experimental and control groups on the variable Confidence in Personal Involvements, as measured by the Marathon Group Questionnaire.

Sub Ho:17b There will be no significant differences between non-heroin users in the experimental and control groups on the variable Confidence in Personal Involvements, as measured by the Marathon Group Questionnaire.

Ho:18 There will be no significant differences between experimental and control group subjects on the variable Counseling Readiness, as measured by the Marathon Group Questionnaire.

Sub Ho:18a There will be no significant differences between heroin users in the experimental and control groups on the variable Counseling Readiness, as measured by the Marathon Group Questionnaire.

Sub Ho:18b There will be no significant differences between non-heroin users in the experimental and control groups on the variable Counseling Readiness, as measured by the Marathon Group Questionnaire.

Ho:19 There will be no significant differences between experimental and control group subjects on the variable Self Confidence, as measured by the Marathon Group Questionnaire.

Sub Ho:19a There will be no significant differences between heroin users in the experimental and control groups on the variable Self Confidence, as measured by the Marathon Group Questionnaire.

Sub Ho:19b There will be no significant differences between non-heroin users in the experimental and control groups on the variable Self Confidence, as measured by the Marathon Group Questionnaire.

Instruments

Two sets of posttests were administered to all of the experimental and control group subjects. The first set of posttests was given 1 day after the marathon groups were held. The second set of posttests was given to subjects still in the institution at the beginning of the 5th week following the week of the first posttest administration. Fifteen of the inmates who took the first set of tests were unavailable to take the second set of tests because they had left the institution. Three instruments were used at each of the two posttest administrations to assess outcomes: (1) the FIRO-B, (2) a semantic differential, and (3) Marathon Group Questionnaire. A general description of each of these instruments follows.

FIRO-B Scales

The FIRO-B (Consulting Psychologists Press) was developed by William Schutz to measure how individuals relate to other people. The FIRO-B, a Guttman scale, assesses how subjects behave toward other persons, rather than how they feel toward other persons. This instrument has six scales, each of which measures either the behavior an individual expresses toward others or the behavior he wants them to express toward him. The instrument also measures one of three interpersonal dimensions, the inclusion, affection, and control areas. Thus, six sets of scores can be obtained from the FIRO-B including expressed behavior in the control, affection, and inclusion areas and wanted behaviors in the control, affection, and inclusion areas. These six scales of the FIRO-B are labeled the e^I, e^A, e^C, w^I, w^A, and w^C scales.

Schutz (1967a, 1967b, 1971, 1973) defined the interpersonal dimensions of inclusion, control, and affection in The FIRO Scales, the manual to the FIRO tests, and in several books related to groups. In The FIRO Scales he defined these interpersonal dimensions in the following way:

> I. The interpersonal need for inclusion is the need to establish and maintain a satisfactory relationship with people with respect to interaction and association....
> C. The interpersonal need for control is the need to establish and maintain a satisfactory relationship with people with respect to control and power. Control behavior refers to the decision-making process between people....
> A. The interpersonal need for affection is the need to establish and maintain a satisfactory relationship with others with respect to love and affection.... (Schutz, 1967a, pp. 4-5)

The FIRO Scales also includes descriptions of what the six scales of the FIRO-B measure:

> e^I I make efforts to include other people in my activities and to get them to include me in theirs....
>
> e^C I try to exert control and influence over things. I take charge of things and tell other people what to do.
>
> e^A I make efforts to become close to people....
>
> w^I I want people to include me in their activities and to invite me to belong, even if I do not make an effort to be included.
>
> w^C I want others to control and influence me....
>
> w^A I want others to express friendly and affectionate feelings toward me and to try to become close to me. (Schutz, 1967a, p. 5)

These six scales were used to test hypotheses one through six.

The FIRO-B scales have a moderately high reliability. As is appropriate for a Guttman scale, the manual reported reliability statistics on the reproducibility of the scales rather than the usual split-half method. Approximately 1,500 college students and Air Force personnel were used to compute the reproducibility of the different scales of the FIRO-B. The e^I, w^I, e^C, w^C, e^A, and w^A scales all showed .94 reproducibility. Approximately 120 Harvard University students were used to compute the test-retest reliabilities for the different scales of the FIRO-B. The test-retest reliabilities of the different scales of the FIRO-B ranged from .71 for the w^C scale to .82 for the e^I scale.

The intercorrelations of the different scales of the FIRO-B were determined from a sample of 1,340 subjects. Schutz stated significant correlations exist between the e and w scales for Inclusion and Affection, and that smaller but statistically significant correlations exist between the I and A scales. Schutz warned the FIRO-B contains non-independent scales, although he recommended maintaining all of the scales.

The FIRO Scales contains information on the content validity and concurrent validity of the FIRO-B. Schutz (1967a) stated that the content

validity of these scales is adequate because all legitimate cumulative scales have adequate content validity. Research on the concurrent validity of the FIRO-B has attempted to determine the relevance of the inclusion, control, and affection scales for the possible psychiatric classification of patients and to relate the dimensions of inclusion, control, and affection to such areas as scientific creativity and differences among occupational groups. The FIRO Scales presents much information showing how members of different occupational groups scored on the different scales of the FIRO-B. Schutz (1967a) maintained that this research indicated striking differences exist between the ways the members of different occupational groups respond on the different scales of the FIRO-B, and that these differences are consistent with occupational stereotypes.

Bloxom (1972), a contributor to The Seventh Mental Measurements Yearbook, reviewed the research related to the FIRO-B, and commented on the general adequacy of the instrument. He rated all the scales of the FIRO-B as being high in internal consistency, and stated that the test-retest reliabilities of the different scales were adequate. Bloxom maintained the non-independence of the different scales of the FIRO-B should not prevent researchers from using all the scales. He suggested that the validity of the FIRO-B suggests its scales are related to non-test interpersonal behavior. He also stated these scale scores are highly correlated with rated creativity, the diagnosis of schizophrenia, and other factors. Bloxom stated of the FIRO-B, "Its subscales show a sufficient degree of relationships to interpersonal behavior and to personality measures to merit its use in research." (Bloxom, 1972, p. 170).

Semantic Differential

The semantic differential was also used to assess the attitude changes of the participants of this research project. The semantic differential was first developed by Osgood, Suci, and Tannenbaum (1957) to measure the meaning of different concepts. They employed opposite adjective pairs to assess how subjects regard a concept, person, or thing. Isaac (1971) stated the semantic differential has three elements which include a concept to be evaluated, a series of undefined scale positions, and polar adjective pairs. Osgood et al. (1957) factor analyzed 76 pairs of opposite adjective pairs to produce the principal factors, the activity, evaluative, and potency scales. Any of the responses a subject makes when rating an adjective pair can be grouped into an evaluative, potency, or activity category. This instrument has been used extensively in many settings and with many populations.

Page and Myrick (1975) used a semantic differential to assess the counseling needs of 85 inmates of the Florida Correctional Institution who were imprisoned for drug or drug related charges. The results obtained by Page and Myrick influenced how concepts were selected for assessment by the semantic differential in this research. Appendix B presents the mean scores for the total population and for heroin and non-heroin users in the evaluative, activity, and potency categories for each of the concepts assessed by Page and Myrick. The higher numerical ratings in Appendix B represent stronger evaluative, activity, and potency loadings. The significant differences in the ways heroin and non-heroin users responded to the concept Drug I Took and to the concept Others Who Use Drugs suggested the use of a factorial design to compare the effects of marathon group treatment on heroin and non-heroin users.

Marathon Group Questionnaire

The Marathon Group Questionnaire developed by this investigator was the third instrument used in this study (Appendix C). This instrument was developed to assess some of the types of behavior changes that Bach, Rogers, and Stoller thought occurred among the participants of marathon groups. Questions on this instrument were written to assess how respondents feel about confrontation, the discussion of feelings, prison officials, counselors and counseling, the development of interpersonal relationships, trust of others, responsibility for self, self-assertion, drugs, and peers in the drug culture.

In 1975, this writer administered this instrument to 107 male and female inmates of the Florida Correctional Institution in order to perform a factor analytic validity study. These respondents included drug offenders as well as inmates imprisoned for other offenses, such as murder. The responses of these inmates were factor analyzed with an Orthogonal Varimax Rotation using the S.P.S.S. Package (Nie, Hull, Jenkins, Steinbrenner, & Bent, 1975). The computer was programmed to force the appearance of three factors.

Three principal factors were obtained from the results of the factor analysis. Factor 1 accounted for 46.8% of the variance, Factor 2 for 37.1% of the variance, and Factor 3 for 16.1% of the total variance of the factors on this questionnaire. A decision was made that questions correlating .40 or higher with any of these three factors were to be used to assess outcomes associated with this factor. If a particular question correlated .40 or higher with more than one factor, this question was to be used to assess outcomes relating to the factor with which the correlation was highest. The Varimax Rotated Factor Matrix obtained from the

statistical printout of this factor analysis is presented as Appendix D. The means and standard deviations obtained from the statistical analysis of the responses of 106 inmates to each question are presented as Appendix E.

It was found that the factors to be used for assessment in this study each contained six to nine questions. The following questions were used to measure the attitudes of respondents on each of the three factors: Factor 1, Questions 7, 9, 10, 11, 13, 15, 29, 32; Factor 2, Questions 4, 5, 8, 14, 17, 24, 25, 38, 39; and Factor 3, Questions 3, 16, 33, 35, 37, and 40. These factors were named by attempting to describe what each of the questions correlating .40 or higher with a factor measured in common.

The first factor was called Confidence in Personal Involvements, the second factor was Counseling Readiness, and the third factor was Self Confidence. These three factors of the Marathon Group Questionnaire were used to test hypotheses 17-19 in this research.

The test-retest reliabilities of the Marathon Group Questionnaire and its three factors were determined by delivering this instrument twice with a 1 week lapse between testinqs to 26 male and female inmates of the Florida Correctional Institution. The test-retest reliability for the total score of the Marathon Group Questionnaire was .90. The test-retest reliabilities of the different scales of this instrument were as follows: .86 for the Confidence in Personal Involvements scale; .84 for the Counseling Readiness scale; and .82 for the Self Confidence scale. The test-retest reliabilities obtained for the total score and for the different scales of the Marathon Group Questionnaire were very high. Further reliability studies need to be performed with this questionnaire to substantiate these findings. Even though this instrument showed

a high test-retest reliability, the scores obtained for individuals on this test should be interpreted with caution because of the limited number of reliability and validity studies which have been performed on the Marathon Group Questionnaire.

Analysis of the Data

The scores of the subjects on the evaluative and potency scales of the semantic differential for each concept and on the scales of the FIRO-B and the Marathon Group Questionnaire were used for analysis. The semantic differential for each concept was scored by assigning numbers from one through seven for each adjective pair so that higher numerical ratings represented stronger evaluative or potency loadings.

Each subject's FIRO-B was scored by key to obtain raw scores for the e^I, w^I, e^C, w^C, e^A, and w^A scales. The range of possible scores for a subject on each of these scales was from zero through nine, nine being the highest score and zero the lowest score a subject could obtain.

Each subject taking the Marathon Group Questionnaire placed a number from one through five beside each question. The scorer reversed the numbers placed by each subject beside questions 3, 4, 5, 8, 14, 17, 24, 25, 33, 35, 38, and 39 so that one was scored as five, five was scored as one and three remained the same for these questions. The numbers placed by the subjects beside questions 7, 9, 10, 11, 13, 15, 16, 29, 32, 37, and 40 were scored as the subject recorded them. The scores on questions 7, 9, 10, 11, 13, 15, 29, and 32 were summed to obtain a total raw score for each participant on the Confidence in Personal Involvements Scale. The scores for questions 4, 5, 8, 14, 17, 24, 25, 38, and 39 were summed to obtain a total raw score for each subject on the Counseling Readiness Scale and the scores for questions 3, 16, 33, 35, 37, and 40 were summed to obtain a

total raw score for each subject on the Self Confidence Scale. The range of possible scores for each individual on the Confidence in Personal Involvements Scale was from 8-40, the range for the Counseling Readiness Scale was 9-45, and the range for the Self Confidence Scale was 6-30. The higher scores for these scales were associated with positive marathon group outcomes and the lower scales were associated with negative outcomes.

Fifty-eight 2x2 analysis of variance procedures were used to assess the hypotheses and sub-hypotheses of this study, 29 2x2 ANOVA's were performed on data from the first posttests, and an equal number were performed on data from the second posttests. The analysis of variance procedures used for the two sets of posttests were as follows: The hypotheses and sub-hypotheses pertaining to each scale of the Marathon Group Questionnaire and the FIRO-B were each assessed by a 2x2 ANOVA. The hypotheses and sub-hypotheses pertaining to each concept of the semantic differential were each assessed by one 2x2 ANOVA for each of the two scales of the semantic differential, the evaluative and potency scales. The first variable for each 2x2 ANOVA represented group (control or experimental) and the second variable represented drug of abuse (heroin or non-heroin use).

Marathon Group Strategy

A Marathon Group Strategy was developed to define the type of treatment the group leaders conducting the marathons would use. The leaders of these groups adhered as closely as possible to the process outlined in this strategy. One goal of the leaders was to help drug offenders develop mutually enhancing ways of relating to peers and authority figures. A second goal was to help group members find solutions to personal problems which contributed to their drug abuse.

The Marathon Group Strategy contains very few exercises in order to enable the marathon groups to evolve in a spontaneous and natural manner. The Marathon Group Strategy includes descriptions of the ground rules, member behaviors, leader behaviors, and group stages of marathon groups. The ground rules section of this strategy is very general and was designed to help promote constructive interactions among group members. The leader behaviors section includes a discussion of when group leaders should use empathy responses and confrontation responses; how leaders should respond to hostility, drug oriented discussions, and transference reactions by group members; and how to identify group themes. The group stages sections includes discussion of the following stages: relaxation, hostility or projection, beginning of intimacy, beginning of feedback, discussion of problems, provision of feedback, modifying behaviors, elation or relaxation, and ending stage. This Marathon Group Strategy is presented as Appendix F.

Experimental Procedures

The procedures of this investigation were carried out in the following order:

1. Three marathon group leaders were trained by the researcher to conduct marathon groups. The researcher served as the fourth leader of the experimental groups. The education of the three trained leaders was 1) an Ed.D. in counselor education, 2) an Ed.S. in counselor education, and 3) a B.A. in history with post graduate courses in counseling. The four prospective leaders were employees of the Florida Correctional Institution and all at the time of this study were or had been staff members of a therapeutic community for drug abusers at the institution. Thus, all of these group leaders

had professional experience in working with incarcerated female drug abusers prior to the time these groups were conducted.

2. Each of these prospective group leaders led at least one 16-hour marathon with the investigator prior to conducting the research groups. These pre-treatment groups were all conducted with incarcerated female drug abusers at Florida Correctional Institution who were not a part of the study.

3. Two other leaders were asked to serve as stand-by leaders in case one of the trained leaders was unable to attend the treatment groups due to sickness or other causes. Neither of the stand-by leaders had led a marathon group with the investigator prior to the time the treatment groups were conducted. All of the prospective leaders and stand-by leaders read the Marathon Group Strategy and discussed it before the date of the experimental groups.

4. Eligible subjects were assigned randomly to one of the two experimental groups or to the control group. A table of random numbers was used to assign subjects to groups.

5. The flip of a coin was the means of randomly assigning one pair of group leaders to each of the experimental groups.

6. One of the trained group leaders (the leader with the Ed.D. degree) was sick the day of the marathons. One of the substitute leaders co-led a group with the investigator. This substitute leader had an Ed.S. degree in counselor education and was also a staff member of the institution where he was working as a drug counselor at the therapeutic community within the institution.

7. The 16-hour marathons were conducted simultaneously at the Florida Correctional Institution.

8. Three sets of tests, a semantic differential, the FIRO-B, and the Marathon Group Questionnaire were delivered to all of the subjects the day following the marathon treatment. The test instruments were scored and the subjects' raw scores, corresponding to each of the scales to be used in this research, were recorded.

9. The same instruments were delivered 4 weeks following the date of the first testing to the subjects still remaining in the institution. Forty-one subjects responded to the instruments at that time. Fifteen subjects did not receive the second set of posttests because they were no longer at the institution.

10. The second set of posttests was scored and each subject's raw scores, corresponding to each of the scales of the instruments to be used in this research, was recorded.

11. Approximately 1 month after the second set of posttests were delivered, interested participants of the control group were given the opportunity to participate in a marathon group.

12. Followup counseling was available to all of the research participants.

With the exceptions noted the experimental procedures were carried out in accordance with the research design. The results are presented in the following chapter.

CHAPTER IV

RESULTS

The population used for this study was incarcerated female drug offenders of the Florida Correctional Institution who, prior to their imprisonment, had serious drug problems which contributed to their imprisonment. All subjects in the control and experimental groups were volunteers who had requested counseling. Subjects were placed randomly in their respective groups through the use of a table of random numbers. Group leaders were also randomly assigned, one pair to each of the two counseling groups. The group leaders conducted the counseling groups on the same day. Leaders followed a marathon group strategy developed by the researcher.

Posttests were administered to the control group subjects and the marathon group subjects. The instruments included a marathon group questionnaire, the FIRO-B, and a semantic differential. All instruments were delivered to the 56 control and experimental group subjects the day following the marathons. These instruments were administered again to those subjects remaining in the institution 4 weeks following the first posttest administration.

Fifty-eight 2 x 2 ANOVA's were performed to assess the outcomes of this study. The data obtained from each 2 x 2 ANOVA presented information on the main effects of treatment vs. control, heroin vs. non-heroin users, and the interaction effects of heroin and non-heroin users with the experimental and control groups. This data was analyzed first by

determining the significance of any interaction effects and then by determining whether the control and experimental group means differed significantly ($p < .05$).

Only one of the 58 2 x 2 ANOVA's which was performed produced a significant ($p < .05$) interaction effect. On the first set of posttests, the expressed inclusion (e^I) scale of the FIRO-B produced an F ratio which was significant ($p < .05$) for the interaction effects of the type of treatment with the drug used. This signified that the scores of heroin users in the control group might differ significantly ($p < .05$) from the scores of heroin users in the experimental group or that the scores of non-heroin users in the control group might differ significantly from the scores of non-heroin users in the control group for this scale. However, when a Scheffé multiple comparisons test was used to compare the scores of heroin users in the experimental and control groups and non-heroin users in the experimental and control groups, no significant differences ($p < .05$) between means were obtained.

The F ratios for the first 28 ANOVA's (related to the first set of posttests) comparing the main effect of the significance of the difference between the means of the control group members and the means of the marathon group members on the scales of all the instruments used for this research are presented in Table 1. The mean scores of the experimental and control groups for the scales on the first set of posttests are presented in Table 2.

The F ratios for the second 29 ANOVA's (related to the second set of posttests) comparing the main effects of the significance of the differences between the means of the control group members and the means of the marathon group members on these same scales are presented in Table 3.

TABLE 1 Results of the Analysis of Variance Procedures Related to the Main Effects of Treatment vs. Control for the First Set of Posttest Data

	Degrees of Freedom	Sum of Squares	F Value	Prob>F
FIRO-B				
e^I (expressed inclusion)	1.55	3.3249	0.7091	0.4035
w^I (wanted inclusion)	1.55	0.0000	0.0000	0.9993
e^C (expressed control)	1.55	3.9316	0.7191	0.4003
w^C (wanted control)	1.55	0.6820	0.1726	0.6795
e^A (expressed affection)	1.55	1.8919	0.3639	0.5489
w^A (wanted affection)	1.55	0.1199	0.0179	0.8939
Semantic Differential				
Evaluative Scales (6 adjective pairs)				
Counseling	1.55	86.0032	1.5700	0.2157
Authority	1.55	27.2935	0.3522	0.5554
Drugs I Took	1.55	25.4867	0.2895	0.5928
Others Who Use Drugs	1.55	54.7325	0.9409	0.3365
Parents	1.55	5.1032	0.0909	0.7643
Women	1.55	107.0880	2.5363	0.1172
Men	1.55	1.7839	0.0366	0.8490
The Future	1.55	1.2603	0.0289	0.8657
The Past	1.55	10.6055	0.1440	0.7058
My Real Self	1.55	67.2276	1.8650	0.1778

TABLE 1 (continued)

	Degrees of Freedom	Sum of Squares	F Value	Prob>F
Potency Scale (6 adjective pairs)				
Counseling	1.55	4.3229	0.1582	0.6924
Authority	1.55	9.5248	0.2309	0.6329
Drugs I Took	1.55	44.3041	0.9277	0.3398
Others Who Use Drugs	1.55	10.5162	0.2485	0.6202
Parents	1.55	0.0000	0.0000	0.9998
Women	1.55	14.6975	1.0320	0.3143
Men	1.55	0.7855	0.0375	0.8471
The Future	1.55	160.0560	4.5983	**0.0366
The Past	1.55	15.1540	0.4223	0.5186
My Real Self	1.55	1.0034	0.0432	0.8361
Marathon Group Questionnaire				
CIPI (Confidence in Personal Involvements)	1.55	84.4808	4.0498	**0.0493
CRS (Counseling Readiness)	1.55	15.3042	0.5052	0.4803
SC (Self Confidence)	1.55	11.0669	0.9641	0.3306

p .005 ***
p .05 **
p .10 *

TABLE 2 Comparisons of the Means of Experimental and Control Groups for the First Set of Posttest Data

	Experimental Group Means	Control Group Means
FIRO-B		
e^I (expressed inclusion)	4.3571	3.8214
w^I (wanted inclusion)	2.9286	2.7857
e^C (expressed control)	2.2857	2.8214
w^C (wanted control)	2.7143	2.8929
e^A (expressed affection)	3.2500	3.5357
w^A (wanted affection)	3.2500	3.2857
Semantic Differential		
Evaluative Scales (6 adjective pairs)		
Counseling	34.9643	32.3929
Authority	24.4643	23.0714
Drugs I Took	24.2857	22.8571
Others Who Use Drugs	20.9643	19.0714
Parents	32.5357	31.9286
Women	31.0357	28.1071
Men	28.0357	27.5714
The Future	36.1786	36.3214
The Past	26.3571	25.3571
My Real Self	35.6429	33.3214
Potency Scales (6 adjective pairs)		
Counseling	26.7143	26.1071
Authority	31.0357	30.1429
Drugs I Took	29.7500	28.2143
Others Who Use Drugs	27.2143	26.5000
Parents	25.4643	25.4643
Women	22.1429	23.2143
Men	26.0357	26.3929
The Future	24.0714	27.3214
The Past	25.5714	24.5357
My Real Self	22.9643	22.7500
Marathon Group Questionnaire		
CIPI Scale	28.1071	25.6071
CRS Scale	34.5714	33.3929
SC Scale	24.7857	23.8214

TABLE 3 Results of the Analysis of Variance Procedures Related to the Main Effects of Treatment vs. Control for the Second Set of Posttest Data

	Degrees of Freedom	Sum of Squares	F Value	Prob>F
FIRO-B				
e^I (expressed inclusion)	1.40	0.4971	0.1533	0.6976
w^I (wanted inclusion)	1.40	6.4368	0.6699	0.4182
e^C (expressed control)	1.40	0.0349	0.0061	0.9383
w^C (wanted control)	1.40	14.8404	2.0975	0.1557
e^A (expressed affection)	1.40	1.2062	0.1917	0.6640
w^A (wanted affection)	1.40	41.7148	10.3571	***0.0026
Semantic Differential				
Evaluative Scales (6 adjective pairs)				
Counseling	1.40	6.3605	0.1718	0.6808
Authority	1.40	0.0007	0.0002	0.9967
Drugs I Took	1.40	52.1650	0.8327	0.3672
Others Who Use Drugs	1.40	131.1713	3.0210	*0.0903
Parents	1.40	57.9997	1.2453	0.2715
Women	1.40	8.3673	0.2466	0.6224
Men	1.40	74.3154	2.1333	0.1523
The Future	1.40	14.7840	0.3447	0.5606
The Past	1.40	10.9060	0.1847	0.6698
My Real Self	1.40	1.1345	0.0313	0.8605

TABLE 3 (continued)

	Degrees of Freedom	Sum of Squares	F Value	Prob>F
Potency Scales (6 adjective pairs)				
Counseling	1.40	8.6663	0.4447	0.5089
Authority	1.40	24.6430	0.9683	0.3313
Drugs I Took	1.40	47.5494	1.0423	0.3137
Others Who Use Drugs	1.40	32.2943	1.1649	0.2873
Parents	1.40	49.0571	3.2189	*0.0808
Women	1.40	36.4800	2.6043	0.1148
Men	1.40	1.3214	0.0904	0.7653
The Future	1.40	105.3871	5.6980	**0.0221
The Past	1.40	0.0497	0.0017	0.9666
My Real Self	1.40	60.9035	3.0012	*0.0913
Marathon Group Questionnaire				
CIPI Scale	1.40	38.2284	1.5606	0.2192
CRS Scale	1.40	11.3787	0.7164	0.4026
SC Scale	1.40	1.7062	0.1912	0.6644

p .005 ***
p .05 **
p .10 *

TABLE 4 Comparisons of the Means of Experimental and Control Groups for the Second Set of Posttest Data

	Experimental Group Means	Control Group Means
FIRO-B		
e^I (expressed inclusion)	4.2381	4.3000
w^I (wanted inclusion)	2.5714	3.1000
e^C (expressed control)	2.6667	2.7000
w^C (wanted control)	2.5238	3.6500
e^A (expressed affection)	3.1905	3.3500
w^A (wanted affection)	2.0000	3.7500
Semantic Differential		
Evaluative Scales (6 adjective pairs)		
Counseling	31.1429	31.5000
Authority	23.7143	24.0000
Drugs I Took	23.0000	20.6000
Others Who Use Drugs	21.7143	18.2000
Parents	32.8095	30.2500
Women	29.5714	28.6000
Men	28.1429	25.1000
The Future	34.4286	35.3500
The Past	25.2381	23.9000
My Real Self	33.0952	33.1500
Potency Scales (6 adjective pairs)		
Counseling	25.9524	26.9000
Authority	28.6667	30.1500
Drugs I Took	29.2381	31.7500
Others Who Use Drugs	27.3810	25.7000
Parents	24.4286	26.8500
Women	24.2857	22.2500
Men	26.2857	26.1500
The Future	23.3333	26.5000
The Past	24.9524	25.3000
My Real Self	24.9048	22.4000
Marathon Group Questionnaire		
CIPI Scale	27.8095	25.6000
CRS Scale	34.7619	33.8500
SC Scale	24.3333	23.9500

The mean scores of the experimental and control groups for the scales on the second set of posttests are presented in Table 4.

The first hypothesis stated:

Ho:1 There will be no significant differences between experimental and control group subjects on the variable of expressed behavior in the area of inclusion, as measured by the FIRO-B.

The two related sub-hypotheses were:

Sub Ho:1a There will be no significant differences between heroin users in the experimental and control groups on the variable of expressed behavior in the area of inclusion, as measured by the FIRO-B.

Sub Ho:1b There will be no significant differences between non-heroin users in the experimental and control groups on the variable of expressed behavior in the area of inclusion, as measured by the FIRO-B.

There were no significant differences ($p < .05$) between the control and experimental group subjects, heroin users in the control and experimental groups, or non-heroin users in the control and experimental groups on the e^{I} (expressed inclusion) scale of the FIRO-B. No significant differences were found either on the first posttest or second posttest administrations. Thus Ho:1, Ho:1a, and Ho:1b were not rejected ($p < .05$).

The second hypothesis stated:

Ho:2 There will be no significant differences between the experimental and control group subjects on the variable of wanted behavior in the area of inclusion, as measured by the FIRO-B.

The two related sub-hypotheses were:

Sub Ho:2a There will be no significant differences between

heroin users in the experimental and control groups on the variable of wanted behavior in the area of inclusion, as measured by the FIRO-B.

Sub Ho:2b There will be no significant differences between non-heroin users in the experimental and control groups on the variable of wanted behavior in the area of inclusion, as measured by the FIRO-B.

Ho:2, Ho:2a, and Ho:2b were not rejected either on the first or second posttest administrations.

The third hypothesis stated:

Ho:3 There will be no significant differences between experimental and control group subjects on the variable of expressed behavior in the area of control, as measured by the FIRO-B.

The two related sub-hypotheses were:

Sub Ho:3a There will be no significant differences between heroin users in the experimental and control groups on the variable of expressed behavior in the area of control, as measured by the FIRO-B.

Sub Ho:3b There will be no significant differences between non-heroin users in the experimental and control groups on the variable of expressed behavior in the area of control, as measured by the FIRO-B.

Ho:3, Ho:3a, and Ho:3b were not rejected either on the first or second posttest administrations.

The fourth hypothesis stated:

Ho:4 There will be no significant differences between experimental and control group subjects on the variable of wanted behavior in the area of control, as measured by the FIRO-B.

The two related sub-hypotheses were:

Sub Ho:4a There will be no significant differences between heroin users in the experimental and control groups on the variable of wanted behavior in the area of control, as measured by the FIRO-B.

Sub Ho:4b There will be no significant differences between non-heroin users in the experimental and control groups on the variable of wanted behavior in the area of control, as measured by the FIRO-B.

On the second posttest administration, the control group subjects tended to score higher than the experimental group subjects on the w^C (wanted control) scale (Table 3). The control group subjects also scored slightly higher on the first posttest administration on the w^C scale of the FIRO-B. However, none of these differences were significant ($p < .05$). Therefore, Ho:4, Ho:4a, and Ho:4b were not rejected on either of the posttest administrations.

The fifth hypothesis stated:

Ho:5 There will be no significant differences between experimental and control group subjects on the variable of expressed behavior in the area of affection, as measured by the FIRO-B.

The two related sub-hypotheses were:

Sub Ho:5a There will be no significant differences between heroin users in the experimental and control groups on the variable of expressed behavior in the area of affection, as measured by the FIRO-B.

Sub Ho:5b There will be no significant differences between non-heroin users in the experimental and control groups on the variable of expressed behavior in the area of affection, as measured by the FIRO-B.

Ho:5, Ho:5a, and Ho:5b were not rejected on either of the posttest administrations.

The sixth hypothesis stated:

Ho:6 There will be no significant differences between experimental and control group subjects on the variable of wanted behavior in the area of affection, as measured by the FIRO-B.

The two related sub-hypotheses were:

Sub Ho:6a There will be no significant differences between heroin users in the experimental and control group on the variable of wanted behavior in the area of affection, as measured by the FIRO-B.

Sub Ho:6b There will be no significant differences between non-heroin users in the experimental and control groups on the variable of wanted behavior in the area of affection, as measured by the FIRO-B.

On the first posttest administration, the treatment group subjects scored only slightly lower on the w^A (wanted affection) scale of the FIRO-B than the control group subjects, but Ho:6, Ho:6a, and Ho:6b were not rejected on the first posttest administration. However, on the second posttest administration, the treatment group subjects did score significantly lower ($p < .05$) than the control group subjects on the w^A scale. Thus, Ho:6, Ho:6a, and Ho:6b were rejected on the second posttest administration.

The seventh hypothesis stated:

Ho:7 There will be no significant differences between experimental and control group subjects on the variable Counseling, as measured by the evaluative and potency scales of a semantic differential.

The two related sub-hypotheses were:

Sub Ho:7a There will be no significant differences between heroin users in the experimental and control groups on the variable Counseling, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:7b There will be no significant differences between non-heroin users in the experimental and control groups on the variable Counseling, as measured by the evaluative and potency scales of a semantic differential.

Ho:7, Ho:7a, and Ho:7b were not rejected either on the first or second posttest administrations.

The eighth hypothesis stated:

Ho:8 There will be no significant differences between experimental and control group subjects on the variable Authority, as measured by the evaluative and potency scales of a semantic differential.

The two related sub-hypotheses were:

Sub Ho:8a There will be no significant differences between heroin users in the experimental and control groups on the variable Authority, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:8b There will be no significant differences between non-heroin users in the experimental and control groups on the variable Authority, as measured by the evaluative and potency scales of a semantic differential.

Ho:8, Ho:8a, and Ho:8b were not rejected either on the first or second posttest administrations.

The ninth hypothesis stated:

Ho:9 There will be no significant differences between experimental and control group subjects on the variable Drugs I Took, as measured by the evaluative and potency scales of a semantic differential.

The two related sub-hypotheses were:

Sub Ho:9a There will be no significant differences between heroin users in the experimental and control groups on the variable Drugs I Took, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:9b There will be no significant differences between non-heroin users in the experimental and control groups on the variable Drugs I Took, as measured by the evaluative and potency scales of a semantic differential.

Ho:9, Ho:9a, and Ho:9b were not rejected either on the first or second posttest administrations.

The tenth hypothesis stated:

Ho:10 There will be no significant differences between experimental and control group subjects on the variable Others Who Use Drugs, as measured by the evaluative and potency scales of a semantic differential.

The two related sub-hypotheses were:

Sub Ho:10a There will be no significant differences between heroin users in the experimental and control groups on the variable Others Who Use Drugs, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:10b There will be no significant differences between non-heroin users in the experimental and control groups on the variable Others Who Use Drugs, as measured by the evaluative and potency scales of a semantic differential.

There was a slight tendency for the marathon group participants to evaluate Others Who Use Drugs higher than the control group participants on the first posttest administration. On the second posttest administration, the experimental group members evaluated Others Who Use Drugs even higher when their scores were compared with the scores of the control group participants. The experimental group members also had a slight tendency to regard the potency of Others Who Use Drugs as being higher than did the control group members on both the first posttest administration and on the second posttest administration. However, Ho:10, Ho:10a, and Ho:10b were not rejected because none of these differences between the scores of the marathon group participants and the control group participants were significant ($p < .05$).

The eleventh hypothesis stated:

Ho:11 There will be no significant differences between experimental and control group subjects on the variable Parents, as measured by the evaluative and potency scales of a semantic differential.

The two related sub-hypotheses were:

Sub Ho:11a There will be no significant differences between heroin users in the experimental and control groups on the variable Parents, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:11b There will be no significant differences between non-heroin users in the experimental and control groups on the variable Parents, as measured by the evaluative and potency scales of a semantic differential.

There was no particular trend apparent when the evaluative subscales of the control and marathon group participants and the potency subscales of

the control and marathon group participants were compared on the concept Parents on the first posttest administration. However, on the second posttest administration, the marathon group participants tended to score higher on the evaluative scale but lower on the potency scale than did the control group members on Parents. None of these differences were significant ($p < .05$). Therefore, Ho:11, Ho:11a, and Ho:11b were not rejected.

The twelfth hypothesis stated:

Ho:12 There will be no significant differences between experimental and control group subjects on the variable Women, as measured by the evaluative and potency scales of a semantic differential.

The two related sub-hypotheses were:

Sub Ho:12a There will be no significant differences between heroin users in the experimental and control groups on the variable Women, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:12b There will be no significant differences between non-heroin users in the experimental and control groups on the variable Women, as measured by the evaluative and potency scales of a semantic differential.

The marathon group participants tended to evaluate Women higher than the control group participants on both the first posttest administration and on the second posttest administration. The marathon group participants regarded the potency of Women as being lower than the control group participants on the first posttest administration but higher than the control group participants on the second posttest administration. Since none of these differences were significant ($p < .05$) Ho:12, Ho:12a, and Ho:12b were not rejected.

The thirteenth hypothesis stated:

Ho:13 There will be no significant differences between experimental and control group subjects on the variable Men, as measured by the evaluative and potency scales of a semantic differential.

The two related sub-hypotheses were:

Sub Ho:13a There will be no significant differences between heroin users in the experimental and control groups on the variable Men, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:13b There will be no significant differences between non-heroin users in the experimental and control groups on the variable Men, as measured by the evaluative and potency scales of a semantic differential.

Ho:13, Ho:13a, and Ho:13b were not rejected either on the first or second posttest administrations.

The fourteenth hypothesis stated:

Ho:14 There will be no significant differences between experimental and control group subjects on the variable The Future, as measured by the evaluative and potency scales of a semantic differential.

The two related sub-hypotheses were:

Sub Ho:14a There will be no significant differences between heroin users in the experimental and control groups on the variable The Future, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:14b There will be no significant differences between non-heroin users in the experimental and control groups on the variable The Future, as measured by the evaluative and potency scales of a semantic differential.

There were no significant differences ($p < .05$) between the ways control and experimental group subjects scored on the evaluative scales on either of the posttest administrations for The Future. Ho:14, Ho:14a, and Ho:14b were not rejected as these hypotheses related to the evaluative scales on either of the posttest administrations. On the other hand, there were significant differences ($p < .05$) between the ways experimental and control group subjects responded to the potency scale of The Future on the first posttest administration and on the second posttest administration. Therefore Ho:14, Ho:14a, and Ho:14b were rejected on the first and second posttest administrations as these hypotheses related to the potency scale of The Future.

The fifteenth hypothesis stated:

Ho:15 There will be no significant differences between the experimental and control group subjects on the variable The Past, as measured by the evaluative and potency scales of a semantic differential.

The two related sub-hypotheses were:

Sub Ho:15a There will be no significant differences between heroin users in the experimental and control groups on the variable The Past, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:15b There will be no significant differences between non-heroin users in the experimental and control groups on the variable The Past, as measured by the evaluative and potency scales of a semantic differential.

Ho:15, Ho:15a, and Ho:15b were not rejected either on the first or second posttest administrations.

The sixteenth hypothesis stated:

Ho:16 There will be no significant differences between experimental and control group subjects on the variable My Real Self, as measured by the evaluative and potency scales of a semantic differential.

The two related sub-hypotheses were:

Sub Ho:16a There will be no significant differences between heroin users in the experimental and control groups on the variable My Real Self, as measured by the evaluative and potency scales of a semantic differential.

Sub Ho:16b There will be no significant differences between non-heroin users in the experimental and control groups on the variable My Real Self, as measured by the evaluative and potency scales of a semantic differential.

The experimental group subjects tended to score higher than the control group subjects on My Real Self on the first posttesting on the evaluative scale. These results were not maintained on the second set of posttests. On the other hand, there were almost no differences between the scores of the experimental and control group subjects on the first posttest administration on the potency scale but on the second posttest administration the experimental group subjects tended to score higher than the control group subjects. None of the differences, however, were significant ($p < .05$). Therefore Ho:16, Ho:16a, and Ho:16b were not rejected either on the first or second posttest administrations.

The seventeenth hypothesis stated:

Ho:17 There will be no significant differences between the experimental and control group subjects on the variable Confidence in Personal Involvements, as measured by the Marathon Group Questionnaire.

The two related sub-hypotheses were:

Sub Ho:17a There will be no significant differences between heroin users in the experimental and control groups on the variable Confidence in Personal Involvements, as measured by the Marathon Group Questionnaire.

Sub Ho:17b There will be no significant differences between non-heroin users in the experimental and control groups on the variable Confidence in Personal Involvements, as measured by the Marathon Group Questionnaire.

On the first posttest administration, the experimental group subjects scored significantly higher ($p < .05$) than the control group subjects on the CIPI scale of the Marathon Group Questionnaire. These significant differences between the scores of the control and experimental subjects, however, were not maintained on the second set of posttests, although the experimental group subjects did score higher than the control group subjects on the second posttest. Ho:17, 17a, and 17b were rejected on the first posttest administration but failed to be rejected on the second posttest administration.

The eighteenth hypothesis stated:

Ho:18 There will be no significant differences between experimental and control group subjects on the variable Counseling Readiness, as measured by the Marathon Group Questionnaire.

The two related sub-hypotheses were:

Sub Ho:18a There will be no significant differences between heroin users in the experimental and control groups on the variable Counseling Readiness, as measured by the Marathon Group Questionnaire.

Sub Ho:18b There will be no significant differences between non-heroin users in the experimental and control groups on the variable Counseling Readiness, as measured by the Marathon Group Questionnaire.

There was a very slight tendency for the experimental group subjects to score higher than the control group subjects on the CRS Scale of the Marathon Group Questionnaire, both on the first posttest administration and on the second posttest administration. None of these differences approached significance ($p < .05$). Therefore Ho:18, Ho:18a, and Ho:18b were not rejected on either of the posttest administrations.

The nineteenth hypothesis stated:

Ho:19 There will be no significant differences between experimental and control group subjects on the variable Self Confidence, as measured by the Marathon Group Questionnaire.

The two related sub-hypotheses were:

Sub Ho:19a There will be no significant differences between heroin users in the experimental and control groups on the variable Self Confidence, as measured by the Marathon Group Questionnaire.

Sub Ho:19b There will be no significant differences between non-heroin users in the experimental and control groups on the variable Self Confidence, as measured by the Marathon Group Questionnaire.

There was a slight tendency on the SC Scale, similar to the other scales of the Marathon Group Questionnaire, for the experimental group subjects to score higher than the control group subjects on both the first posttest and the second posttest. Since none of these differences approached significance ($p < .05$) Ho:19, Ho:19a, and Ho:19b were not rejected either on the first or second posttest administrations.

The null hypotheses and null sub-hypotheses which were rejected included Ho:6, Ho:6a, and Ho:6b on the second posttest administration, Ho:14, Ho:14a, and Ho:14b on the first and second posttest administrations, and Ho:17, Ho:17a, and Ho:17b on the first posttest administration. A discussion of the implications of this research follows in Chapter V.

CHAPTER V

SUMMARY AND RECOMMENDATIONS

Summary

The purpose of this research was to assess the impact of marathon group counseling on changing selected attitudes of incarcerated female drug abusers. The population studied was female inmates of the Florida Correctional Institution who had major drug problems before being imprisoned. Most of these females were imprisoned because they committed crimes (sales of drugs, armed robbery, grand larceny) to support their drug habits. The effects of treatment on inmates who had been addicted to heroin and on inmates who had abused illicit drugs other than heroin were also assessed.

Two pairs of group leaders conducted two counseling groups on the same day. These groups lasted for 16 hours and were called marathons. The treatment guidelines followed by the group leaders comprise the Marathon Group Strategy (Appendix F).

Fifty-six inmates were selected randomly to participate in the control group and experimental groups. Two pairs of group leaders were assigned randomly to the two experimental groups. Three sets of instruments were used to test the hypotheses of this study: the FIRO-B, a semantic differential, and the Marathon Group Questionnaire. The Posttest Only Control Group Design (Campbell & Stanley, 1966) was used to assess the outcomes of this study. The research participants were

administered two posttests; the first posttest administration was the day following the marathons and the second was given 4 weeks later. The results were analyzed by an analysis of variance procedure.

The findings of this research were undramatic. The marathon group participants scored significantly lower ($p < .05$) than the control group participants on the w^A (wanted affection) scale of the FIRO-B on the second posttest administration, and lower on the potency scale of The Future on a semantic differential on the first and second posttest administrations. The marathon group participants scored significantly higher ($p < .05$) on the first posttest administration of the Confidence in Personal Involvements Scale of the Marathon Group Questionnaire. There were no significant differences ($p < .05$) between the ways the control and experimental group participants scored on any of the other scales of the instruments used for this research.

Conclusions

The purpose of this research was to assess the impact of marathon group counseling on changing certain key attitudes of incarcerated drug abusers. The attitudes which were assessed related to the feelings of the research participants towards interpersonal relationships, counseling, self, others, drugs, the past and future, and authority. The FIRO-B, the Marathon Group Questionnaire, and a semantic differential were the instruments which were used to assess the attitudes of the research participants in these areas. The types of attitude changes which occured as measured by each of these instruments are discussed below with the object of drawing conclusions, based on this study, about the effectiveness of marathon groups as a treatment modality with incarcerated drug abusers.

The FIRO-B assesses how persons form and maintain relationships in the areas of inclusion, control, and affection. It was difficult to discern any major differences in the ways the marathon group members and the control group members responded to most of the scales of the FIRO-B on either the first or second set of posttests. There were no apparent trends when the scores of the marathon and control group participants were compared. Thus, the conclusion must be made that either the FIRO-B failed to assess the manner in which the group participants changed their attitudes in the inclusion, control, and affection areas or that the marathon groups failed to change the attitudes of the participants in these areas.

The one possible exception to the lack of differences in the attitudes of the control and marathon group participants on the scales of the FIRO-B was on the affection scale. On the second posttest administration, the control group participants scored significantly higher ($p < .05$) than the experimental group participants on the wanted affection scale. These results may be interpreted as showing that the wanted affection of the marathon group participants was reduced because of their participation in the marathons. The marathons may have helped to meet the affection needs of the participants.

The Marathon Group Questionnaire was developed by this writer to assess the impact of marathon groups on attitudes of imprisoned drug abusers. The Marathon Group Questionnaire has three scales which were labeled Confidence in Personal Involvements, Counseling Readiness, and Self Confidence. This questionnaire was designed so that higher values associated with each scale (CIPI Scale, CRS Scale,and SC Scale) were also associated with positive marathon group outcomes.

The marathon group participants obtained higher scores on the CIPI Scale, the CRS Scale, and the SC Scale on both posttest administrations than did the control group participants. Although this trend existed, most of the differences between the scores of the marathon group participants and the control group participants were not significant.

The marathon group participants scored significantly higher ($p < .05$) on the Confidence in Personal Involvements Scale on the first posttest administration than did the members of the control group. Thus, the day after the marathons, the group participants appeared to be more confident in their ability to relate to others in a meaningful way than the control group participants. On the second posttest administration, the marathon group participants still scored higher on this scale than the control group participants but the differences were no longer significant ($p < .05$). Therefore, it might be concluded that the marathon group participants did not maintain the same level of confidence in their abilities to relate to others after 1 month as they had 1 day following a marathon group experience.

A semantic differential was used to assess the attitudes of the subjects toward the following concepts: Women, Men, Parents, Authority, The Past, The Future, Counseling, Drugs I Took, Others Who Use Drugs, and My Real Self. There were greater differences between the experimental and control group participants on the potency scales than on the evaluative scales on most of the concepts evaluated by the semantic differential. The only scale of the semantic differential on which there were significant differences between the control group members and the marathon group members was the potency scale for the concept The Future.

On both posttest administrations, marathon group participants scored significantly lower ($p < .05$) on the potency scale for the concept The Future than the control group participants. Whatever differences existed between the control and marathon group members on this scale were maintained over a 1 month time period. The meaning of these differences is somewhat elusive. One possible interpretation is that the marathon group participants became more realistic in their perceptions of The Future which contributed to their regarding The Future as being a somewhat less potent force in their lives. Since correctional offenders often negate or deny the difficulties they may have in adjusting to society, these changes may constitute positive changes for this population.

Limitations

This research had several different types of limitations which may very possibly have confounded the results. One of the major limitations was that most of the persons who participated in this research as control or marathon group participants had previously received some form of individual or group counseling at the Florida Correctional Institution. Therefore, the effects of the marathon groups had to be powerful enough to produce results over and above any benefits the control and marathon group members had previously received from participating in other forms of counseling at F.C.I.

It is possible that many of the research participants already had changed many of their attitudes on a number of scales before they participated in the marathon groups due to their previous counseling involvements. For instance, in this research both control group and marathon group participants evaluated counseling highly on a semantic

differential. The control group participants obtained an average score of between 5 and 6 points (out of 7 possible points) on the evaluative scales on the concept Counseling. Both the control and experimental group subjects had low evaluative scores for Drugs I Took and Others Who Use Drugs. Different results might have been obtained if subjects had been selected randomly into control and marathon groups from a population of imprisoned drug offenders whose experience with counseling was limited rather than extensive.

Another possible limitation of this research involved the instruments used to assess outcomes. Many questionnaires commonly used to assess counseling outcomes are rather primitive. The instruments used to assess the attitudes of the experimental and control group subjects in this research were viewed as among the best available to assess counseling group outcomes, but these instruments had many limitations.

The FIRO-B is a self report inventory which can be faked. The different scales of the instrument are not independent. The major scales of inclusion, affection, and control may not be sensitive to the types of changes the group members should have been expected to make from participating in a marathon group.

The semantic differential also presents problems; it provided a lot of information but it was difficult to interpret the meaning of certain changes. The control and experimental subjects also appeared to be a little confused about the format of the semantic differential. When they were administered this instrument, they did not seem to readily understand the meaning of many of the adjective pairs.

The Marathon Group Questionnaire also has several limitations. The instrument had not been used prior to this study. The instrument is

also a self report scale which can be faked. On the other hand, one of the positive aspects of this instrument was that the changes on the scales of the instrument were easily interpreted. The scales of the instrument measured the types of changes this researcher wished to bring about by the marathon groups.

Another problem affecting the scores on all the instruments was that the inmates of correctional institutions often do not enjoy being tested. A few subjects rushed through the questionnaires when they were administered and seemed bored while taking them. Some subjects had difficulty in reading or understanding the questionnaires, especially the semantic differential. However, it did appear that when most of the subjects took these instruments they answered the questions thoughtfully and carefully.

One further possible limitation of this research was that the instruments which were used did not measure specific factors. The different concepts on the semantic differential were very general. The Marathon Group Questionnaire assessed factors different from both the FIRO-B and the semantic differential. It probably would have been more relevant to have choosen fewer specific variables, such as perceptions of interpersonal relationships, and to have used more instruments to assess more specific factors.

Recommendations

A number of recommendations for further research are suggested. First, instruments which assess specific types of counseling outcomes should be developed. For instance, instruments of high reliability and validity need to be developed which assess such varied therapeutic outcomes as how a person feels toward drugs, interpersonal relationships, family relationships, self, and others. More specifically, the Marathon Group

Questionnaire needs to be evaluated in detail as a prospective instrument to assess the outcomes of group counseling with prisoners.

A second recommendation for further research on marathon groups involves studying the effects of these groups on more specific populations. In this research, for instance, the effects of marathon groups on incarcerated female heroin abusers might have been undertaken by assessing outcomes related to the perceptions of this population of interpersonal relationships. Clients who are currently actively involved in counseling should probably be avoided as much as possible as the subjects of research because of the confounding effects of the counseling they are receiving. When it is feasible, the control and group members should be randomly selected from a population which is receiving a minimum of counseling.

The effects of marathon groups on various prison populations need to be studied much more extensively. There has been very little research on the effects of marathons in correctional settings. The effects of marathon groups on specific attitudes or behaviors of female imprisoned drug abusers need to be evaluated much more thoroughly. This research project offers only a beginning toward assessing the impact of these groups on this population.

The effects of marathon groups need to be studied on male as well as female populations of drug abusers. The effectiveness of marathon group leaders who use many exercises should be compared with the effectiveness of group leaders who use no exercises to facilitate the group process. Marathon group leaders who conduct their groups according to a particular model (i.e., Rogerian groups, Gestalt groups, marathon groups led in the manner of Bach) should have their results compared with the results of the advocates of other models. The effects of marathon groups in

different types of correctional institutions, for instance, minimum, medium, and close custory institutions, need to be assessed. The effects of groups led by non-professional staff, or by ex-addicts, need to be compared with the effects of groups led by the professional staff (psychologists, psychiatrists, counselors) of correctional institutions. There are numerous ways in which the effects of different types of marathon groups on different prison populations of drug abusers need to be studied.

There were very few results detected by the instruments which were used to assess the outcomes of this study. This study presents only very limited evidence that marathon group counseling is effective in changing the attitudes of imprisoned female drug offenders as results were obtained on only three of 29 scales used to assess attitude changes. More extensive study is necessary to determine the potential of marathon group counseling with this population.

APPENDIX A

WORD EXERCISES

Name_____ Date_____

On every page place an X on one of the spaces between every pair of words. The X's should be on the space between each word pair which describes how you feel about the subject named at the top of that page.

COUNSELING

GOOD	____:	____:	____:	____:	____:	____:	____:	BAD
WEAK	____:	____:	____:	____:	____:	____:	____:	STRONG
PLEASURABLE	____:	____:	____:	____:	____:	____:	____:	PAINFUL
HUMOROUS	____:	____:	____:	____:	____:	____:	____:	SERIOUS
NEGATIVE	____:	____:	____:	____:	____:	____:	____:	POSITIVE
SUCCESSFUL	____:	____:	____:	____:	____:	____:	____:	UNSUCCESSFUL
CONSTRAINED	____:	____:	____:	____:	____:	____:	____:	FREE
SEVERE	____:	____:	____:	____:	____:	____:	____:	LENIENT
HARD	____:	____:	____:	____:	____:	____:	____:	SOFT
FALSE	____:	____:	____:	____:	____:	____:	____:	TRUE
LIGHT	____:	____:	____:	____:	____:	____:	____:	HEAVY
UNSOCIABLE	____:	____:	____:	____:	____:	____:	____:	SOCIABLE

AUTHORITY

GOOD	____:	____:	____:	____:	____:	____:	____:	BAD
WEAK	____:	____:	____:	____:	____:	____:	____:	STRONG
PLEASURABLE	____:	____:	____:	____:	____:	____:	____:	PAINFUL
HUMOROUS	____:	____:	____:	____:	____:	____:	____:	SERIOUS
NEGATIVE	____:	____:	____:	____:	____:	____:	____:	POSITIVE
SUCCESSFUL	____:	____:	____:	____:	____:	____:	____:	UNSUCCESSFUL
CONSTRAINED	____:	____:	____:	____:	____:	____:	____:	FREE
SEVERE	____:	____:	____:	____:	____:	____:	____:	LENIENT
HARD	____:	____:	____:	____:	____:	____:	____:	SOFT
FALSE	____:	____:	____:	____:	____:	____:	____:	TRUE
LIGHT	____:	____:	____:	____:	____:	____:	____:	HEAVY
UNSOCIABLE	____:	____:	____:	____:	____:	____:	____:	SOCIABLE

DRUGS I TOOK

GOOD	____:	____:	____:	____:	____:	____:	____:	BAD
WEAK	____:	____:	____:	____:	____:	____:	____:	STRONG
PLEASURABLE	____:	____:	____:	____:	____:	____:	____:	PAINFUL
HUMOROUS	____:	____:	____:	____:	____:	____:	____:	SERIOUS
NEGATIVE	____:	____:	____:	____:	____:	____:	____:	POSITIVE
SUCCESSFUL	____:	____:	____:	____:	____:	____:	____:	UNSUCCESSFUL
CONSTRAINED	____:	____:	____:	____:	____:	____:	____:	FREE
SEVERE	____:	____:	____:	____:	____:	____:	____:	LENIENT
HARD	____:	____:	____:	____:	____:	____:	____:	SOFT
FALSE	____:	____:	____:	____:	____:	____:	____:	TRUE
LIGHT	____:	____:	____:	____:	____:	____:	____:	HEAVY
UNSOCIABLE	____:	____:	____:	____:	____:	____:	____:	SOCIABLE

OTHERS WHO USE DRUGS

GOOD	____:	____:	____:	____:	____:	____:	____:	BAD
WEAK	____:	____:	____:	____:	____:	____:	____:	STRONG
PLEASURABLE	____:	____:	____:	____:	____:	____:	____:	PAINFUL
HUMOROUS	____:	____:	____:	____:	____:	____:	____:	SERIOUS
NEGATIVE	____:	____:	____:	____:	____:	____:	____:	POSITIVE
SUCCESSFUL	____:	____:	____:	____:	____:	____:	____:	UNSUCCESSFUL
CONSTRAINED	____:	____:	____:	____:	____:	____:	____:	FREE
SEVERE	____:	____:	____:	____:	____:	____:	____:	LENIENT
HARD	____:	____:	____:	____:	____:	____:	____:	SOFT
FALSE	____:	____:	____:	____:	____:	____:	____:	TRUE
LIGHT	____:	____:	____:	____:	____:	____:	____:	HEAVY
UNSOCIABLE	____:	____:	____:	____:	____:	____:	____:	SOCIABLE

PARENTS

GOOD	____:	____:	____:	____:	____:	____:	____:	BAD
WEAK	____:	____:	____:	____:	____:	____:	____:	STRONG
PLEASURABLE	____:	____:	____:	____:	____:	____:	____:	PAINFUL
HUMOROUS	____:	____:	____:	____:	____:	____:	____:	SERIOUS
NEGATIVE	____:	____:	____:	____:	____:	____:	____:	POSITIVE
SUCCESSFUL	____:	____:	____:	____:	____:	____:	____:	UNSUCCESSFUL
CONSTRAINED	____:	____:	____:	____:	____:	____:	____:	FREE
SEVERE	____:	____:	____:	____:	____:	____:	____:	LENIENT
HARD	____:	____:	____:	____:	____:	____:	____:	SOFT
FALSE	____:	____:	____:	____:	____:	____:	____:	TRUE
LIGHT	____:	____:	____:	____:	____:	____:	____:	HEAVY
UNSOCIABLE	____:	____:	____:	____:	____:	____:	____:	SOCIABLE

WOMEN

GOOD	____:	____:	____:	____:	____:	____:	____:	BAD
WEAK	____:	____:	____:	____:	____:	____:	____:	STRONG
PLEASURABLE	____:	____:	____:	____:	____:	____:	____:	PAINFUL
HUMOROUS	____:	____:	____:	____:	____:	____:	____:	SERIOUS
NEGATIVE	____:	____:	____:	____:	____:	____:	____:	POSITIVE
SUCCESSFUL	____:	____:	____:	____:	____:	____:	____:	UNSUCCESSFUL
CONSTRAINED	____:	____:	____:	____:	____:	____:	____:	FREE
SEVERE	____:	____:	____:	____:	____:	____:	____:	LENIENT
HARD	____:	____:	____:	____:	____:	____:	____:	SOFT
FALSE	____:	____:	____:	____:	____:	____:	____:	TRUE
LIGHT	____:	____:	____:	____:	____:	____:	____:	HEAVY
UNSOCIABLE	____:	____:	____:	____:	____:	____:	____:	SOCIABLE

MEN

GOOD	____:	____:	____:	____:	____:	____:	____:	BAD
WEAK	____:	____:	____:	____:	____:	____:	____:	STRONG
PLEASURABLE	____:	____:	____:	____:	____:	____:	____:	PAINFUL
HUMOROUS	____:	____:	____:	____:	____:	____:	____:	SERIOUS
NEGATIVE	____:	____:	____:	____:	____:	____:	____:	POSITIVE
SUCCESSFUL	____:	____:	____:	____:	____:	____:	____:	UNSUCCESSFUL
CONSTRAINED	____:	____:	____:	____:	____:	____:	____:	FREE
SEVERE	____:	____:	____:	____:	____:	____:	____:	LENIENT
HARD	____:	____:	____:	____:	____:	____:	____:	SOFT
FALSE	____:	____:	____:	____:	____:	____:	____:	TRUE
LIGHT	____:	____:	____:	____:	____:	____:	____:	HEAVY
UNSOCIABLE	____:	____:	____:	____:	____:	____:	____:	SOCIABLE

THE FUTURE

GOOD	____:	____:	____:	____:	____:	____:	____:	BAD
WEAK	____:	____:	____:	____:	____:	____:	____:	STRONG
PLEASURABLE	____:	____:	____:	____:	____:	____:	____:	PAINFUL
HUMOROUS	____:	____:	____:	____:	____:	____:	____:	SERIOUS
NEGATIVE	____:	____:	____:	____:	____:	____:	____:	POSITIVE
SUCCESSFUL	____:	____:	____:	____:	____:	____:	____:	UNSUCCESSFUL
CONSTRAINED	____:	____:	____:	____:	____:	____:	____:	FREE
SEVERE	____:	____:	____:	____:	____:	____:	____:	LENIENT
HARD	____:	____:	____:	____:	____:	____:	____:	SOFT
FALSE	____:	____:	____:	____:	____:	____:	____:	TRUE
LIGHT	____:	____:	____:	____:	____:	____:	____:	HEAVY
UNSOCIABLE	____:	____:	____:	____:	____:	____:	____:	SOCIABLE

THE PAST

GOOD	____:	____:	____:	____:	____:	____:	____:	BAD
WEAK	____:	____:	____:	____:	____:	____:	____:	STRONG
PLEASURABLE	____:	____:	____:	____:	____:	____:	____:	PAINFUL
HUMOROUS	____:	____:	____:	____:	____:	____:	____:	SERIOUS
NEGATIVE	____:	____:	____:	____:	____:	____:	____:	POSITIVE
SUCCESSFUL	____:	____:	____:	____:	____:	____:	____:	UNSUCCESSFUL
CONSTRAINED	____:	____:	____:	____:	____:	____:	____:	FREE
SEVERE	____:	____:	____:	____:	____:	____:	____:	LENIENT
HARD	____:	____:	____:	____:	____:	____:	____:	SOFT
FALSE	____:	____:	____:	____:	____:	____:	____:	TRUE
LIGHT	____:	____:	____:	____:	____:	____:	____:	HEAVY
UNSOCIABLE	____:	____:	____:	____:	____:	____:	____:	SOCIABLE

MY REAL SELF

GOOD	____:	____:	____:	____:	____:	____:	____:	BAD
WEAK	____:	____:	____:	____:	____:	____:	____:	STRONG
PLEASURABLE	____:	____:	____:	____:	____:	____:	____:	PAINFUL
HUMOROUS	____:	____:	____:	____:	____:	____:	____:	SERIOUS
NEGATIVE	____:	____:	____:	____:	____:	____:	____:	POSITIVE
SUCCESSFUL	____:	____:	____:	____:	____:	____:	____:	UNSUCCESSFUL
CONSTRAINED	____:	____:	____:	____:	____:	____:	____:	FREE
SEVERE	____:	____:	____:	____:	____:	____:	____:	LENIENT
HARD	____:	____:	____:	____:	____:	____:	____:	SOFT
FALSE	____:	____:	____:	____:	____:	____:	____:	TRUE
LIGHT	____:	____:	____:	____:	____:	____:	____:	HEAVY
UNSOCIABLE	____:	____:	____:	____:	____:	____:	____:	SOCIABLE

APPENDIX B

Mean Scores for Total Population on
Semantic Differential Concepts Obtained from
Research by Page and Myrick, 1975
(N=85)

Concept	Activity	Evaluative	Potency
Women	*5.197	*5.106	*3.962
Men	4.412	4.606	4.159
School	*4.629	*5.571	*4.694
My Vocational Future	*4.856	*5.750	*4.545
Parents	*4.388	*5.709	*4.435
Drugs I Took	*4.476	*3.371	*5.038
Others Who Use Drugs	*4.324	*3.009	*4.212
Past	*4.524	*3.241	*4.212
Future	*4.547	*6.121	*4.368
As I See Me	*4.476	*5.385	*4.185
As I Would Like To Be	*4.429	*6.656	*4.126

*.05 level of significance on t-test of independence

Mean Scores for Heroin Users and Non-Heroin Users on
Semantic Differential Concepts Obtained from
Research by Page and Myrick, 1975
(N=39 Heroin Users, 46 Non-Heroin Users)

Concept	Activity		Evaluative		Potency	
	Heroin	Non-H	Heroin	Non-H	Heroin	Non-H
Women	4.808	4.880	4.949	4.902	3.987	3.940
Men	4.410	4.429	4.737	4.495	4.173	4.147
School	4.756	4.527	5.549	5.565	4.609	4.712
My Vocational Future	4.814	4.891	5.852	5.663	4.397	4.652
Parents	4.423	4.359	5.795	5.576	4.545	4.402
Drugs I Took	*4.192	*4.832	**2.859	**3.804	*5.391	*4.739
Others Who Use Drugs	**3.910	**4.592	*2.647	*3.315	*4.538	*3.935
Past	4.590	4.556	3.378	3.125	4.308	4.130
Future	4.468	4.560	6.333	5.940	4.410	4.332
As I See Me	4.462	4.484	5.635	5.174	4.269	4.114
As I Would Like to Be	4.346	4.364	6.673	6.641	4.333	3.951

*.05 level of significance on t-test of independence
**.01 level of significance on t-test of independence

APPENDIX C

Marathon Group Questionnaire

For each statement below, decide which of the responses best applies for you. Place the number of the response in the space at the left of each statement. Respond as honestly as possible.

1. Strongly Agree
2. Agree
3. Undecided
4. Disagree
5. Strongly Disagree

_____ 1. I feel awkward when others discuss their problems with me.

_____ 2. Others misunderstand me.

_____ 3. I care about others.

_____ 4. I can benefit from counseling.

_____ 5. I am able to confront others in ways they can accept.

_____ 6. I can influence the direction of my life.

_____ 7. I don't think people like me.

_____ 8. I respect the staff of this institution.

_____ 9. Others provoke me into saying things I don't mean to say.

_____ 10. I have difficulty understanding other people's feelings.

_____ 11. I have difficulty controlling my anger when others misinterpret my actions or feelings.

_____ 12. People treat me fairly.

_____ 13. I don't have much to offer in conversations with people.

_____ 14. I respect police officers.

_____ 15. I shut out people when they criticize me.

_____ 16. I am suspicious when others try to help me.

_____ 17. I plan to seek out counseling in the future.

_____ 18. I can put into words what others feel.

_____ 19. I avoid my problems until circumstances make me take action.

_____ 20. Others are interested in what I say.

_____ 21. The establishment is out to get me.

_____ 22. Other people use me.

_____ 23. I trust people who are close to me.

_____ 24. I listen carefully to others when they speak.

_____ 25. Counseling can help people help themselves.

_____ 26. It is easy for me to make decisions.

_____ 27. I actively seek others' opinions of me.

_____ 28. This institution has had a positive influence on my life.

_____ 29. I keep my feelings to myself.

_____ 30. I often feel as if fate were against me.

_____ 31. I am a loveable person.

_____ 32. I don't know what to do when I get mad.

_____ 33. My goals in life are clear.

_____ 34. I avoid becoming personally involved with others.

_____ 35. If I work hard, I can make a success of life.

_____ 36. I find it difficult to talk with staff.

_____ 37. I dislike myself.

_____ 38. I feel at ease in groups.

_____ 39. I feel counselors can be trusted with confidential information.

_____ 40. I have not met many people I like.

APPENDIX D

Varimax Rotated Factor Matrix from the Results of the Factor Analysis of the Marathon Group Questionnaire

Variable	Factor 1	Factor 2	Factor 3
Q1	0.36955	-0.22892	0.00414
Q2	0.39460	-0.03944	-0.15432
Q3	-0.22121	0.06753	0.52055
Q4	0.06235	0.47449	0.01757
Q5	-0.01143	0.40378	0.07353
Q6	0.16242	0.01349	0.27896
Q7	0.53966	-0.14335	0.27828
Q8	-0.17438	0.44756	0.16241
Q9	0.55782	-0.06417	0.09120
Q10	0.66347	-0.06587	0.03160
Q11	0.54661	0.05463	-0.02191
Q12	0.01012	0.00278	0.34409
Q13	0.40645	0.02955	0.03062
Q14	-0.18542	0.44411	0.03523
Q15	0.49001	-0.13047	0.15650
Q16	0.25188	0.07567	0.40985
Q17	-0.04957	0.64216	0.00163
Q18	0.14912	0.29514	-0.01470
Q19	0.36920	-0.21043	0.36733
Q20	0.20673	0.17392	0.29588
Q21	0.25835	0.34509	0.14464
Q22	0.34178	0.16049	0.04281
Q23	-0.06519	0.14864	0.34489
Q24	-0.00765	0.51509	0.22176
Q25	-0.01702	0.54525	0.21484
Q26	0.25292	0.17589	0.33674
Q27	-0.13180	0.33668	-0.18840
Q28	-0.03270	0.34351	0.05805
Q29	0.45101	0.11750	0.05207
Q30	0.34749	-0.13593	0.32487
Q31	-0.12520	0.34664	0.33741
Q32	0.44800	0.13363	0.14613
Q33	0.07561	0.23882	0.40813
Q34	0.35454	-0.15093	0.26916
Q35	-0.09944	0.18363	0.48737
Q36	0.09763	0.09230	0.21160
Q37	0.17584	-0.03070	0.48501
Q38	0.03691	0.43877	0.38822
Q39	0.22049	0.46341	0.08229
Q40	0.27429	0.06313	0.48186

APPENDIX E

Means and Standard Deviations of the Responses of
106 Subjects to the Questions of the
Marathon Group Questionnaire

Variable	Mean	Standard Deviation
Q1	2.5472	1.1722
Q2	2.6604	1.0591
Q3	1.6226	0.7740
Q4	2.0472	1.1245
Q5	2.0849	0.8061
Q6	1.7358	0.9691
Q7	1.9434	0.8489
Q8	2.3962	1.2164
Q9	2.2358	1.1089
Q10	2.4151	0.9843
Q11	2.5660	1.1631
Q12	2.2075	0.7396
Q13	2.3208	1.0650
Q14	2.4717	1.1145
Q15	2.5755	1.1037
Q16	2.5000	1.0071
Q17	2.4434	1.1471
Q18	2.6415	0.9970
Q19	2.8491	1.1856
Q20	2.4811	0.8192
Q21	1.9811	0.8393
Q22	2.3962	1.0390
Q23	1.8302	0.9204
Q24	1.9623	0.7919
Q25	1.6887	0.8436
Q26	2.4717	0.9681
Q27	2.9151	1.1801
Q28	2.3302	1.2010
Q29	3.2358	1.2154
Q30	2.5094	1.0442
Q31	2.1226	0.9924
Q32	2.1981	0.9198
Q33	2.1509	1.0401
Q34	2.9245	1.1604
Q35	1.5000	0.7715
Q36	2.6509	1.1795
Q37	1.6038	0.8910
Q38	2.5755	1.1292
Q39	2.5472	1.1138
Q40	1.9811	1.0326

APPENDIX F

Marathon Group Strategy

Ground Rules

Participants in the marathons will agree to the following ground rules. These ground rules will provide them with examples of behaviors which are most likely to contribute to meaningful experiences in a group. The group leaders will be flexible when presenting these ground rules. These ground rules will be presented to members as guidelines which are open for discussion and subject to change by group consensus.

1. Everyone is to remain with the group until it is over.
2. The members will decide by majority vote when to eat or have other breaks from group interaction.
3. Members are to share their impressions of each other with one another.
4. The group proceedings will be kept confidential.

Member Behaviors

The group leaders will attempt to help group members develop positive ways of relating to others. They will encourage members to experiment with certain growth enhancing behaviors. The assumption is made that as the group members practice these behaviors their attitudes toward themselves and others will change positively. These leaders will not coerce members to change. The group leaders will encourage the group members to change their behavior and attitudes in the following directions:

1. Listening carefully when others express feelings and opinions.
2. Developing the ability to empathize with others by reflecting feelings.

3. Expressing feelings openly and honestly to receptive and concerned persons.
4. Developing a capacity to care for others.
5. Making an increased number of positive self references.
6. Becoming more assertive without becoming aggressive.
7. Finding workable solutions to problems.
8. Developing the ability to use a specific model of feedback.
9. Learning to evaluate feedback without becoming defensive.
10. Developing an increased capacity to listen to positive as well as negative feedback.
11. Developing an increased willingness to express their feelings about the behavior of the group leaders directly to the group leaders.
12. Developing insight into how their needs affect their interactions with others.
13. Gaining a recognition that behavior has consequences in terms of the reactions of others.
14. Assuming responsibility for their behavior.
15. Expressing trust in counselors.
16. Expressing trust in their peers.
17. Gaining an increased capacity to recognize that authority figures who are concerned for their welfare can be trusted.

Leader Behaviors

The group leaders will be presented with many opportunities to interact with group members and to facilitate group interactions. They will interact with members and facilitate group interactions in ways which are described below.

Using Empathy Responses

The group leaders may empathize with marathon group members when these members describe concerns or problems they have. They can use what Wittmer and Myrick (1974) described as reflection of feeling responses to demonstrate they understand the feelings of their clients. These responses will be used by the group leaders whenever group members express genuine, non-manipulative feelings.

Using Confrontation Responses

The group leaders may confront clients with their feelings when they feel something for a long period of time, and when they think confronting an individual will be constructive to the client and/or group interaction. Counselors may confront clients when clients avoid listening to feedback from others; or when clients encourage other clients to use drugs, or when clients engage in other self-defeating behaviors. The counselors will confront clients on specific behaviors they notice which elicit either positive or negative feelings from them. They will describe the behaviors they noticed from a client, and the feelings they had when they noticed these behaviors. The group leaders will generally encourage group members to confront one another rather than assuming the primary responsibility for handling confrontation interactions. Generally these leaders will attempt to maintain a supportive role in the group by helping their members express feedback to other members and by helping members react to feedback openly and constructively.

Responding to Hostility Expressed by Group Members

Group members may express hostile feelings relating to how they feel toward the group leaders, the institution, or other group members. When

a group member provides feedback to a group leader, the leader should demonstrate to this group member he is listening to the feedback and carefully considering the merit of the feedback. The group leader may respond to feedback by reflecting the feelings of the member to show he understands the feelings which prompted a member to provide feedback (Appendix G). When group members express hostile feelings toward the institution the group leader may again reflect the feelings of these group members. The leaders should not place themselves in the position of defending the institution because if this occurs the group members may deduce they will not be permitted to express their real feelings in the group. The group leaders should encourage members to focus as much as possible on their own behavior and feelings rather than on continually discussing the institution. If one member expresses unrestrained hostility toward another member the group leaders should encourage the other members to help the hostile member examine the type of feedback he is providing and how it affects others.

Responding to Drug Oriented Discussions

Many times persons with drug problems enjoy reminiscing about the feelings they obtained from drugs, or the excitement of being a member of the drug culture. These types of discussions can reinforce drug seeking behaviors among the group members; therefore, the leaders must handle these types of transactions in a constructive way. When it is possible, the leader may divert discussions about the pleasurable feelings associated with drugs to other topics. The leaders may also help members understand the feelings they have which contribute to their compulsive drug use (Appendix G). The group leaders may help members realize how much of their psychic energy is channeled into thinking about drugs, or

how much they depend on talking about drugs to feel comfortable in their relationships with others.

The group leaders should try to avoid openly disapproving of drugs unless they have close and open relationships with members or they may unwittingly encourage the group members to defend drug use. Many drug abusers are rebellious. They may subconsciously or consciously use talking about drugs as a means of expressing hostility toward society or authority. When this occurs, the leaders may help clients express hostility more openly and directly.

Responding to Transference Reactions

Wolf and Schwartz (1962) extensively described the manner in which the members of therapy groups develop transference reactions toward the group leader or other group members. The group leaders of these marathon groups will encourage members to compare the ways they feel toward them with the ways they felt toward other authority figures or parental figures. When group members make such comparisons, the leaders will help members express their feelings and openly encourage, in a permissive way, the expressions of these feelings. The group leaders, however, will avoid interacting with members in detached ways solely as transference figures but instead will interact with members as real persons with real feelings. Wolf and Schwartz (1962) maintained such a method of handling transference reactions is effective because group members work through transference feelings by learning to interact with transference figures as real persons rather than by maintaining stereotyped views of them. Wolf and Schwartz stated that group members gain insight regarding their compulsive behavior patterns when they work through transference problems and thus learn how to behave differently in the future.

Identifying Group Themes

One of the primary responsibilities of the group leaders will be to identify the types of discussions which occur in their groups, and the ways different members interact with each other. The leaders will help group members verbally identify these group themes, and gain insight into the motivations of others. Examples of the types of themes which may occur in marathons in a prison setting include the questioning of authority and the development of feelings of intimacy and trust within the group. The group leader should help members become aware of the evolution of the group. The group members should be helped to recognize the group stages through which their marathon progresses.

The primary goal of the group leaders will be to serve as facilitators of group interaction among members. The group leaders must avoid forcing the group to develop according to their preconceived views of how it should develop. The leaders will encourage member to member interactions more than leader to member interactions.

Group Stages

The marathon group will be conducted in an unstructured manner. The group leaders will try to recognize the stages the group proceeds through and facilitate interaction among members during each stage. Imprisoned drug abusers may need help in learning empathy skills or in learning how to confront other members in acceptable ways. Unless the group members receive this help, they may maintain stereotyped ways of relating and avoid developing honest and open relationships in the group. The group leaders may present a confrontation model and/or teach members how to reflect feelings during the group. The following stages, which may vary for different marathons, are described as a general guide for marathon group leaders.

Relaxation Stage

The group members will need to relax when entering the group. Many members will be suspicious or tense at first because offenders learn to be on guard while living in a correctional institution. The group leaders should help the members relax by encouraging them to discuss how they feel about being in the group. The leaders should also encourage the members to express doubts the members harbor toward them. The reservations the members may feel about sharing their real feelings with authority figures will need to be resolved before the group can progress. The group leaders should encourage their members to assume responsibility for discussing their feelings in the group, and not to shift responsibility to the leaders for structuring the group interactions.

Hostility or Projection Stage

The group members may express feelings of resentment about being in a correctional institution or about their mistreatment in society. Some members may state any problems they have were caused by their imprisonment. The group leaders should help members express their feelings; at the same time, the leaders should encourage the members to offer feedback concerning how hostile members behave in relationship to their feelings. For instance, a group leader may help an inmate express feelings of resentment about her mistreatment in the institution and the group members may confront this inmate about misbehaving in front of a matron. The group leaders should not defend the institution, or attack the institution. The group members will naturally shift the focus of the discussion in the group away from the institution as trust develops among the group members and for the leaders.

Beginning of Intimacy Stage

The members may provide feedback to other group members which is judgmental or which is unfair or inaccurate. The group leaders may need to help group members develop empathy skills so that these members can learn to offer accurate feedback to others. A modified version of an exercise described by Wittmer and Myrick (1974, pp. 111-113) may be used at this stage to help members learn to describe their feelings to others.

1. Divide the group into five groups with three members in each group. Have each group member be either a talker, a facilitator, or an observer.
2. The talker should speak to the facilitator for three minutes, regarding her feelings toward the group, toward drugs, toward her parents, toward a spouse or boy friend. The facilitator should help the speaker express her feelings about this topic.
3. During the three minutes the observer records her observations of the interactions between the facilitator and speaker by completing a Facilitator's Report Card (Wittmer and Myrick, 1974, p. 112).
4. After the facilitator and speaker have finished talking, the observer provides feedback for two minutes regarding what she observed, and recorded on the Facilitator's Report Card.
5. Roles are then switched among the members of each triad. Each talker chooses another topic and the exercise is repeated.
6. Each member in the triad should serve as an observer, talker, and facilitator.

The leaders will discuss the concepts of empathy and reflection of feelings before engaging in the use of this exercise. The use of this

exercise will be followed by a discussion of how the members felt about using reflection of feeling responses with each other.

An alternative to this exercise is for the leaders to encourage a discussion of how well the group members think they are listening to one another. In order to help group members learn to listen, the group leaders may ask members to summarize feedback provided to them before these members respond to the feedback. The group leaders may discuss the concept of empathy with group members (even if they do not use the empathy exercise). When discussing empathy, the leaders will encourage members to discuss whether empathy has a role in the group as a type of interaction.

Beginning of Feedback Stage

One of the most significant types of group interaction in marathon groups is the provision of feedback. Feedback can help group members learn about the games or manipulations they use when interacting with one another. Feedback can help these members become aware of how they characteristically interact with others. Feedback can also reinforce the positive changes members make in the group. For instance, members generally receive positive feedback for honestly exploring personal problem areas, for exploring alternative ways of acting in relation to problems, and for developing honest and caring relationships with other group members.

The group leaders will help group members gain a knowledge of how they can provide feedback which does not label others and which others can accept without becoming defensive. Rogers (1971) encouraged a person providing feedback to another member of his group to describe specific behaviors he noticed about this other member, and then to describe the feelings he experienced when he observed these behaviors. This type of feedback is non-evaluative, and the person giving feedback does not label

the personality of others in negative ways. The group leaders will try to help group members develop constructive ways of providing feedback which are effective in the group and in society.

The group leaders may use the following exercise to help members learn to give and listen to feedback:

1. The group members will count off in order to divide into two smaller groups, each to be composed of seven persons.
2. One group leader will be a member of each of these smaller groups, and will help the members of this group provide feedback to one another.
3. Each leader will instruct the persons in his/her group how to use a specific model of feedback. The persons providing feedback will describe a specific behavior or series of behaviors she noticed about the member to whom she is giving feedback. She will then describe how she felt toward this person when she noticed these behaviors.
4. The leader of each group will instruct group members to provide feedback relating to behaviors which are significant. The member providing the feedback should have fairly strong feelings relating to the behaviors she is describing.
5. The group members will not be forced to participate in this exercise.
6. Each member of a small group will provide feedback to each of the other members of that group.
7. Once each member of a small group has received feedback from all the other members of that group, the members may discuss in this smaller group how they felt when they received feedback.

Discussion of Problems Stage

The members may have personal problems related to their past or drug addiction which they need to express and work through. The group leaders will empathize with members who share their concerns or problems with the group. When the leaders think they have gained the respect and cooperation of a particular group member, they may decide to provide feedback concerning the manner in which this member is acting in response to her problems. Most group members will emulate the behavior of the group leaders. For this reason, the members will expect each other to make an attempt to express an understanding of the feelings of group members who express genuine problems or concerns. Members will also provide feedback to any person discussing her problems, possibly including evaluations of how well this person is handling her problems.

Some group members may not be adept at empathizing with members who describe areas of personal concern. Some members may continually manipulate other members by acting selfishly in the group. One way this can occur is for one member to demand to have everyone's attention in the group without letting others express themselves. When such manipulations occur, the members will begin to provide feedback to each other concerning the ways specific members are relating to one another in the group.

Provision of Feedback Stage

During this stage, the group members will confront each other about the characteristic ways each member has related to other members during the course of the group. Some members will be given positive feedback and some members will be given negative feedback. When a group member is given negative feedback, she should be helped by the group leader to examine her behavior non-defensively. The leader should support the efforts of this

group member to make positive behavior changes. This group member will begin to receive positive feedback from the other group members when she shows concern for the feelings of other members, or stops manipulating others. Some members may disagree with the ways other members perceive their behavior or motives. The group leaders should respect the choice of members who decide not to change their ways of acting in the group. These members, however, will probably continue to receive feedback from the other group members.

The group leaders will encourage the members to provide most of the feedback during this stage. They will provide support to members who need their support when receiving feedback. The leaders, on occasion, may choose to confront a member if they feel this member can benefit from their feedback.

Modifying Behaviors Stage

The group leaders will try to prompt group members to help each other change behaviors which are self-destructive or destructive to others. The group members will begin to care for one another as they gain trust and repsect for one another during the group. The members will learn new ways of relating to others which involve the development of caring, non-manipulative relationships.

Elation or Relaxation Stage

The members will experience a sense of elation as a result of the positive relationships they experience in the group. They will learn human relationships have an existential meaning which can enrich their lives. They will experience a sense of timelessness as they become engrossed in the caring relationships they develop in the group. The

group members will learn constructive human relationships can be used as a viable alternative to drugs which can make them feel better about the quality of their lives.

Ending Stage

The leaders should end the group on a positive note. They should be certain group members do not leave the group with unresolved feelings concerning feedback they received. For this reason the leaders should encourage the members to discuss how they feel about the marathon experience once it is ready to end. Members should be encouraged to discuss unresolved feelings they have toward other members, or the group leaders. They should also discuss any questions they have concerning their group experience.

The leaders may ask their members to participate in a strength bombardment exercise at this point in the group. Each member will receive positive feedback from all the members of the group. One member will receive feedback from everyone in the group before another member receives feedback. Each member will receive feedback concerning some characteristic the other group member admires or likes about her. Once each member has received positive feedback from the other members the group will end.

APPENDIX G

Examples of Leader Responses to Client Behaviors

(Empathy Response)

Client -- I am having a very hard time in this institution. Nobody likes me. I stay in my room all the time.
Leader -- You are feeling very lonely.
Client -- Yes, that's it. I....

(Confrontation Response)

Client -- I feel heroin is ok for me and for anyone else who wants to use it. The only reason straight people don't like drugs is because they are too uptight to try them.
Leader -- Let's examine what you are saying. You appear to be avoiding looking at some of the unfavorable effects heroin has had on your life.
Client -- That may be true. I....

(Hostility Response)

Client -- You (to group leader) make me very uneasy. You sit without saying anything. I'll bet you are going to tell custody about what we are discussing.
Leader -- I really sense you are uneasy. Tell me more. I appreciate this feedback.
Client -- All right! I....

(Response to Drug Oriented Discussion)

Client -- Man, I really enjoy doing drugs. I dig listening to music and getting high. I can relax totally. I feel as if the world is mellow.
Leader -- You really enjoy relaxing. I sense you may be tense when you don't use drugs.
Client -- That's true. I....

(Transference Response)

Client -- You remind me of my father. He used to sit quietly until he got angry. Then he would beat me.
Leader -- I do feel you are uneasy. Tell me more about your father.
Client -- Ok. I....

REFERENCES

Bach, G. R. The marathon group: Intensive practice of intimate interaction. Psychological Reports, 1966, 18, 995-1002.

Bach, G. R. Marathon group dynamics: I. Some functions of the professional group facilitator. Psychological Reports, 1967a, 20, 995-999.

Bach, G. R. Marathon group dynamics: II. Dimensions of helpfulness: Therapeutic aggression. Psychological Reports, 1967b, 20, 1147-1158.

Bach, G. R. Marathon group dynamics: III. Disjunctive contacts. Psychological Reports, 1967c, 20, 1163-1172.

Becker, H. S. Marihuana: A sociological overview. Mayor LaGuardia's Committee on Marihuana. The marihuana problem in the city of New York, 1944. In David Solomon (Ed.), The marihuana papers. New York: Signet Books, 1966.

Berzins, J. I., & Ross, W. F. Locus of control among opiate addicts. Journal of Consulting and Clinical Psychology, 1973, 40, 84-91.

Blacker, K. H. Aggression and the chronic use of LSD. Journal of Psychedelic Drugs, 1970, 3, 32-37.

Bloxom, B. The FIRO scales. In Oscar Krisen Buros (Ed.), Seventh mental measurements yearbook, New Jersey: The Gryphon Press, 1972.

Braucht, G. N., Brakarsh, D., Follingstad, D., & Berry, K. L. Deviant drug use in adolescence: A review of psychosocial correlates. Psychological Bulletin, 1973, 79, 92-106.

Brecher, E. M. (and the Editors of Consumer Reports). Licit and illicit drugs. Boston: Little, Brown and Company, 1972.

Campbell, A. Seven states of consciousness. New York: Harper and Row, 1974.

Campbell, D. T., & Stanley, J. C. Experimental and quasi-experimental designs for research. Chicago: Rand McNally and Company, 1966.

Canadian Government Commission of Inquiry. The non-medical use of drugs: Interum report of the Canadian Government Commission of Inquiry. Ottawa, Canada: Penguin Books, 1970.

Carey, J. T., & Mandel, J. A. A San Francisco Bay Area "speed" scene. Journal of Health and Social Behavior, 1968, 9, 164-174.

Chambers, C. D. Personality profiles of female narcotics users. An address at the 1971 Annual Conference of American Society of Criminology and International Association of Penal Law. San Juan, Puerto Rico.

Chambers, C. D., Brill, L., & Inciardi, J. A. Barbiturate use, misuse, and abuse. Journal of Drug Issues, 1972, 2, 15-20.

Chambers, C. D., Hinesley, R. K., & Moldestad, M. Narcotics addiction in females: A race comparison. International Journal of the Addictions, 1970, 5, 257-278.

Chambers, C. D., Moffett, A. D., & Jones, J. D. Demographic factors associated with Negro opiate addiction. International Journal of the Addictions, 1968, 3, 329-343.

Chambers, W. M., & Ficek, D. E. An evaluation of marathon counseling. International Journal of Group Psychotherapy, 1970, 24, 372-379.

Check, F. E., Newell, S., & Sarett, M. The illicit LSD group--some preliminary observations. In Bernard Aaronson and Humphry Osmond (Eds.), Psychedelics. New York: Anchor Books, 1970.

Chein, I. Narcotic use among juveniles. In John A. O'Donnell and John C. Ball (Eds.), Narcotic addiction. New York: Harper and Row, 1966.

Cooperstock, R. Sex differences in the use of mood-modifying drugs: An explanatory model. Journal of Health and Social Behavior, 1971, 12, 238-244.

Coulson, W. Inside a basic encounter group. Counseling Psychologist, 1970, 2, 1-27.

Crowley, T. J. The reinforcers for drug abuse: Why people take drugs. Comprehensive Psychiatry, 1972, 13, 51-62.

Cuskey, W. R., Premkumar, T., & Sigel, L. Survey of opiate addiction among females in the United States between 1850 and 1970. Grassroots, August, 1974 Supplement, Narcotics (8/74), 1-15.

Densen-Gerber, J. We mainline dreams: The Odyssey House story. Baltimore: Penguin Books, 1973.

Diamond, M. J., & Shapiro, J. L. Method and paradigm in encounter group research. Journal of Humanistic Psychology, 1975, 15, 59-70.

Dohner, V. A. Alternatives to drugs: A new approach to drug education. Journal of Drug Education, 1972a, 2, 3-22.

Dohner, V. A. Motives for drug use: Adult and adolescent. Psychosomatics. 1972b, 13, 317-324.

Eddy, N. The church vs. heroin. In Dan Wakefield (Ed.), The addict. Greenwich, Conn.: Fawcett Publications, 1963.

Einstein, S., & Garitano, W. Treating the drug abuser: Problems, factors and alternatives. International Journal of the Addictions, 1972, 7, 321-331.

Eldridge, W. B. Myths and facts. In Dan Wakefield (Ed.), The addict. Greenwich, Conn.: Fawcett Publications, 1963.

Essig, C. Barbiturate dependence. In Robert T. Harris, William M. McIsaac and Charles R. Schuster (Eds.), Drug dependence. Dallas: University of Texas Press, 1970.

Feldman, H. W. Ideological supports to becoming and remaining a heroin addict. National Clearing House for Mental Health Information. Drug dependence--N.I.M.H. #3, March, 1970.

Finestone, H. Narcotics and criminality. In John A. O'Donnell and John C. Ball (Eds.), Narcotic addiction. New York: Harper and Row, 1966.

Fort, J. The marijuana abuser and the abuser of psychedelic-hallucinogens. In John G. Cull and Richard E. Hardy (Eds.), Types of drug abusers. Springfield, Illinois: Charles C. Thomas, 1974.

Fort, J. P. The psychodynamics of drug addiction and group psychotherapy. International Journal of Group Psychotherapy, 1955, 5, 150-156.

Fort, J. P. Heroin addiction among young men. In John A. O'Donnell and John C. Ball (Eds.), Narcotic addiction. New York: Harper and Row, 1966.

Foulds, M. L., Guinan, J. F., & Warehime, R. G. Marathon group: changes in a measure of dogmatism. Small Group Behavior, 1974, 5, 387-392.

Gendreau, P., & Gendreau, L. P. A theoretical note on personality characteristics of heroin addicts. Journal of Abnormal Psychology, 1973, 82, 139-140.

Gibb, J. R. The effects of human relations training. In Allen E. Bergin and Sol L. Garfield (Eds.), Handbook of psychotherapy and behavior change. New York: John Wiley and Sons, Inc., 1971.

Grinspoon, L. Marihuana reconsidered. New York: Bantam Books, 1971.

Grinspoon, L., & Hedblom, P. The speed culture: Amphetamine use and abuse in America. Cambridge, Massachusetts: Harvard University Press, 1975.

Guinan, J. F., & Foulds, M. L. Marathon group: Facilitator of personal growth. Journal of Counseling Psychology, 1970, 17, 145-149.

Guinan, J. F., Foulds, M. L., & Wright, J. C. Do the changes last? A six-month follow-up of a marathon group. Small Group Behavior, 1973, 4, 177-180.

Harrison, R. Cognitive change and participation in a sensitivity-training laboratory. Journal of Consulting Psychology, 1966, 30, 517-520.

Hendricks, W. J. Use of multifamily counseling groups in treatment of male narcotic addicts. International Journal of Group Psychotherapy, 1971, 21, 84-90.

Hochman, J. S., & Brill, N. Q. Chronic marijuana use and psychosocial adaptation. American Journal of Psychiatry, 1973, 130, 132-140.

Isaac, S. Handbook in research and evaluation. San Diego, California: Robert R. Knapp, 1971.

Isbell, H. Medical aspects of opiate addiction. In John A. O'Donnell and John C. Ball (Eds.), Narcotic addiction. New York: Harper and Row, 1966.

Jaffe, D. T. A counseling institution is an oppressive environment. Journal of Humanistic Psychology, 1973, 13, 25-46.

Jones, A. P. Personality and value differences related to use of LSD-25. International Journal of the Addictions, 1973, 8, 549-557.

Jones, D. S., & Medvene, A. M. Self-actualization effects of a marathon growth group. Journal of Counseling Psychology, 1975, 22, 39-43.

Kendall, F. F., & Pittel, S. M. Three portraits of the young drug user: Comparisons of MMPI group profiles. Journal of Psychedelic Drugs, 1971, 3, 63-67.

Ketai, R. Peer-observed psychotherapy with institutionalized narcotic addicts. Archives of General Psychology, 1973, 29, 51-53.

Kilmann, P. R. Direct and nondirect marathon group therapy and internal-external control. Journal of Counseling Psychology, 1974, 21, 380-384.

Kilmann, P. R., & Averbach, S. M. Effects of marathon group therapy on trait and state anxiety. Journal of Consulting and Clinical Psychology, 1974, 42, 607-612.

Kimball, R., & Gelso, C. J. Self-actualization in a marathon growth group: Do the strong get stronger? Journal of Counseling Psychology, 1974, 21, 38-42.

King, M., Payne, D. C., & McIntire, W. G. The impact of marathon and prolonged sensitivity training on self-acceptance. Small Group Behavior, 1973, 4, 414-423.

Kolansky, H., & Moore, W. T. Toxic effects of chronic marihuana use. Journal of the American Medical Association, 1972, 222, 35-41.

Kramer, J. The Synanon experiment. In Dan Wakefield (Ed.), The addict. Greenwich, Conn.: Fawcett Publications, 1963.

Kramer, J. C. Introduction to amphetamine abuse. In Everett H. Ellinwood, and Sidney Cohen (Eds.), Current Concepts on Amphetamine Abuse. Proceedings of a Workshop at Duke University Medical Center, June 5-6, 1970. Rockville, Maryland: National Institute of Mental Health, 1970.

Kramer, J. C., Vitezslav, S. F., & Littlefield, D. C. Amphetamine abuse: Patterns and effects of high doses taken intravenously. Journal of the American Medical Association, 1967, 201, 89-93.

Kroeker, E. E. Pretesting as a confounding variable in evaluating an encounter group. Journal of Counseling Psychology, 1974, 21, 548-552.

Kruschke, D., & Stoller, F. H. Face to face with the drug addict: An account of an intensive group experience. Federal Probation, 1967, 31, 47-52.

Laurie, P. Drugs: Medical, psychological and social facts. Baltimore: Penguin Books, 1971.

Lewis, V., & Glaser, D. Lifestyles among heroin users. Federal Probation, 1974, 38, 21-28.

Lichtenstein, P. M. Narcotic addiction. In John A. O'Donnell and John C. Ball (Eds.), Narcotic addiction. New York: Harper and Row, 1966.

Lieberman, M. A. Joy less facts? The response to Schutz, Smith and Rowan. Journal of Humanistic Psychology, 1975, 15, 49-54.

Lieberman, M. A., Yalom, I. D., & Miles, M. B. Encounter groups: First facts. New York: Basic Books, 1973a.

Lieberman, M. A., Yalom, I. D., & Miles, M. B. Encounter: The leader makes the difference. Psychology Today, 1973b, March, 69-76.

Lindesmith, A. R. Beginnings of wisdom. In Dan Wakefield (Ed.), The addict. Greenwich, Conn.: Fawcett Publications, 1963a.

Lindesmith, A. R. Torture by law. In Dan Wakefield (Ed.), The addict. Greenwich, Conn.: Fawcett Publications. 1963b.

Lindesmith, A. R. Basic problems in the social psychology of addiction and a theory. In John A. O'Donnell and John C. Ball (Eds.), Narcotic addiction. New York: Harper and Row, 1966.

Marks, S. E., Conry, R. T., & Foster, S. F. Comment the marathon group hypothesis: An unanswered question. Journal of Counseling Psychology, 1973, 20, 185-187.

Miles, M. B. Rejoinder to Schutz, Smith, and Rowan. Journal of Humanistic Psychology, 1975, 15, 55-58.

Miller, J., Sensenig, J., Stocker, B., & Campbell, R. Value patterns of drug addicts as a function of race and sex. International Journal of the Addictions, 1973, 8, 589-598.

Mills, J. The world of Needle Park. In John A. O'Donnell and John C. Ball (Eds.), Narcotic addiction. New York: Harper and Row, 1966.

Mintz, E. E. Marathon groups: Reality and symbol. New York: Avon Books, 1971.

Myers, A. E., Myers, G. E., Tapp, M. A., & Tapp, J. T. Helping the ex-addict. Personnel and Guidance Journal, 1972, 50, 817-822.

National Commission on Marihuana and Drug Abuse. Marihuana: A signal of misunderstanding. New York: Signet, 1972.

Nie, H. H., Hull, C. H., Jenkins, J. G., Steinbrenner, K., & Bent, D. H. Statistical package for the social services. New York: McGraw Hill, 1975.

Osgood, C. E., Suci, G. T., & Tannenbaum, P. H. The measurement of meaning. Urbana, Illinois: University of Illinois Press, 1957.

Page, R. C., & Myrick, R. D. The counseling needs of incarcerated drug addicts. An Unpublished Manuscript, University of Florida, 1975.

Payne, David. Getting there without drugs. New York: Ballantine Books, 1973.

Posthuma, A. B., & Posthuma, B. W. Some observations on encounter group casualties. Journal of Applied Behavioral Sciences, 1973, 9, 595-608.

Ray, O. Drugs, society and human behavior. Saint Louis: G.V. Mosby Company, 1972.

Raynes, A. E., Climent, C., Patch, V. D., and Ervin, F. Factors related to imprisonment in female heroin addicts. International Journal of the Addictions, 1974, 9, 145-150.

Robbins, T. Characteristics of amphetamine addicts. International Journal of the Addictions, 1970, 5, 183-193.

Rogers, C. On encounter groups. New York: Harper and Row, 1970.

Ross, W. F., McReynolds, W. T., & Berzins, J. I. Effectiveness of marathon group psychotherapy with hospitalized female narcotic addicts. Psychological Reports, 1974, 34, 611-616.

Rowan, J. Encounter group research: No joy? Journal of Humanistic Psychology, 1975, 15, 19-28.

Ruitenbeek, H. M. The new group therapies. New York: Avon Books, 1970.

Saretsky, L. Feedback and measurement. In Elizabeth F. Mintz, Marathon groups: Reality and symbol. New York: Avon Books, 1971.

Schur, E. M. The British system. In Dan Wakefield (Ed.), The addict. Greenwich, Conn.: Fawcett Publications, 1963.

Schutz, W. C. The FIRO scales manual. Palo Alto, California: Consulting Psychologists Press, Inc., 1967a.

Schutz, W. C. Joy. New York: Grove Press, 1967b.

Schutz, W. C. Here comes everybody. New York: Harper and Row, 1971.

Schutz, W. C. Elements of encounter. Big Sur, California: Joy Press, 1973.

Schutz, W. C. Not encounter and certainly not fact. Journal of Humanistic Psychology, 1975, 15, 7-18.

Seldin, N. E. The family of the addict: A review of the literature. International Journal of the Addictions, 1972, 7, 97-107.

Shoenfeld, D. D. The sociological study. Mayor LaGuardia's Committee on Marihuana. The marihuana problem in the city of New York, 1944. In David Solomon (Ed.), The marihuana papers. New York: Signet Books, 1966.

Smith, D. E. LSD, violence and radical religious beliefs. Journal of Psychedelic Drugs, 1970, 3, 38-40.

Smith, P. B. Are there adverse effects on sensitivity training? Journal of Humanistic Psychology, 1975, 15, 29-47.

Smith, R. C. Compulsive methamphetamine abuse and violence in the Haight-Ashbury district. In E. H. Ellinwood and S. Cohen (Eds.), Current concepts on amphetamine abuse. Proceedings of a Workshop, Duke University Medical Center, June 5-6, 1970. Rockville, Maryland; National Institute of Mental Health, 1970.

Steinfeld, G. J. The use of covert sensitization with institutionalized narcotic addicts. International Journal of the Addictions, 1970, 5, 225-232.

Steinfeld, G. T., Rautio, E. A., Rice, A. H., & Egan, M. J. Group covert sensitization with narcotic addicts (further comments). International Journal of the Addictions, 1974, 9, 447-464.

Stoller, F. H. Accelerated interaction: A time-limited approach based on a brief, intensive group. International Journal of Group Psychotherapy, 1968a, 18, 220-235.

Stoller, F. H. Marathon group therapy. In George M. Gazda (Ed.), Innovations to group psychotherapy. Springfield, Illinois: Charles C. Thomas, 1968b.

Task Force on Federal Heroin Addiction Programs. Introduction to treatment and rehabilitation. Grassroots, May 1974 Supplement, Treatment and Rehabilitation (5/74), 1-21.

Thorpe, J. J., & Smith, B. Phases in group development in the treatment of drug addicts. International Journal of Group Psychotherapy, 1955, 3, 66-78.

Treppa, J. A., & Fricke, L. Effects of a marathon group experience. Journal of Counseling Psychology, 1972, 19, 466-467.

Volkman, R., & Cressey, D. R. Differential association and the rehabilitation of drug addicts. In John A. O'Donnell and John C. Ball (Eds.), Narcotic addiction. New York: Harper and Row, 1966.

Wallace, G. B. Summary. Mayor LaGuardia's Committee on Marihuana. The marihuana problem in the city of New York, 1944. In David Solomon (Ed.), The marihuana papers. New York: Signet Books, 1966.

Warner, R. W. Preventing drug abuse: Where are we now? Personnel and Guidance Journal, 1973, 51, 523-528.

Weil, A. The natural mind. Boston: Houghton Mifflin Company, 1972.

Weissman, H. N., Seldman, M., & Ritter, K. Changes in awareness of impact upon others as a function of encounter and marathon group experience. Psychological Reports, 1971, 28, 651-661.

Wesson, D. R., & Smith, D. E. Barbiturate toxicity and the treatment of barbiturate dependence. Journal of Psychedelic Drugs, 1972, 5, 159-165.

Whitlock, F. A. The syndrome of barbiturate dependence. Medical Journal of Australia, 1970, 2, 391-396.

Williams, J. E., & Bates, W. M. Some characteristics of female narcotic addicts. International Journal of the Addictions, 1970, 5, 245-256.

Winich, C. The addict psychology. In Dan Wakefield (Ed.), The addict. Greenwich, Conn.: Fawcett Publications, 1963.

Wittmer, J., & Myrick, R. D. Facilitative teaching: Theory and practice. Pacific Palisades, California: Goodyear Publishing Company, Inc., 1974.

Wolf, A., & Schwartz, E. K. Psychoanalysis in groups. New York: Grune and Stratton, 1962.

Yablonsky, L. Synanon: The tunnel back. Baltimore: Penguin Books, 1965.

Young, E. R., & Jacobson, L. L. Effects of time-extended group experiences on personality characteristics. Journal of Counseling Psychology, 1970, 17, 247-251.

BIOGRAPHICAL SKETCH

Richard Collin Page was born in New York City on June 28, 1943. In 1946 he moved with his family to Cleveland, Ohio. He attended public schools there and graduated from Shaker Heights High School in 1962.

At Denison University, Granville, Ohio, Mr. Page majored in history. He received the Bachelor of Arts from that institution in 1966. In January, 1968, Mr. Page graduated from the University of North Carolina at Chapel Hill with the degree Master of Arts in Teaching. His major was education and his minor was history.

From 1967 until 1969 Mr. Page was employed as a classroom teacher by the Charlotte-Mecklenburg Board of Education, Charlotte, North Carolina. He resigned to enroll at the University of Florida.

Mr. Page received a Rehabilitation Services Administration Grant to study at the University of Florida from 1969-1971. He majored in rehabilitation counseling and was awarded the degree Master of Rehabilitation Counseling in March, 1971. He then worked as a rehabilitation counselor at the Georgia Rehabilitation Center in Warm Springs, Georgia until 1973.

Mr. Page returned to Florida in 1973. While pursuing his doctoral degree, he worked at the Florida Correctional Institution, Lowell, Florida, as academic consultant, supervisor of drug counselors, and as drug abuse counselor.

The degree of Doctor of Philosophy was awarded Mr. Page by the University of Florida in August, 1976. He majored in counselor education with a minor in rehabilitation counseling.

In 1968 Mr. Page was married to the former Anne McLaughlin of Waxhaw, North Carolina. They have one son, Richard Harry Page.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Robert D. Myrick, Chairman
Professor of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Jerald D. Bozarth
Professor of Rehabilitation Counseling

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Paul W. Fitzgerald
Professor of Counselor Education

This dissertation was submitted to the Graduate Faculty of the College of Education and to the Graduate Council, and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

August, 1976

Dean, College of Education

Dean, Graduate School